

EXHIBIT A

SUMMONS

Attorney(s) Callagy Law, PC
Office Address 650 From Rd., Ste. 240
Town, State, Zip Code Paramus, NJ 07652
Telephone Number 201-889-6119
Attorney(s) for Plaintiff Monmouth County Pain Management

Superior Court of
New Jersey

Middlesex County
Law Division

Docket No: MID-L-2063-22

Plaintiff(s)

vs.

Cigna Health and Life Insurance

Company, et al.

Defendant(s)

CIVIL ACTION
SUMMONS

From The State of New Jersey To The Defendant(s) Named Above:

The plaintiff, named above, has filed a lawsuit against you in the Superior Court of New Jersey. The complaint attached to this summons states the basis for this lawsuit. If you dispute this complaint, you or your attorney must file a written answer or motion and proof of service with the deputy clerk of the Superior Court in the county listed above within 35 days from the date you received this summons, not counting the date you received it. (A directory of the addresses of each deputy clerk of the Superior Court is available in the Civil Division Management Office in the county listed above and online at http://www.njcourts.gov/forms/10153_deptyclerklawref.pdf.) If the complaint is one in foreclosure, then you must file your written answer or motion and proof of service with the Clerk of the Superior Court, Hughes Justice Complex, P.O. Box 971, Trenton, NJ 08625-0971. A filing fee payable to the Treasurer, State of New Jersey and a completed Case Information Statement (available from the deputy clerk of the Superior Court) must accompany your answer or motion when it is filed. You must also send a copy of your answer or motion to plaintiff's attorney whose name and address appear above, or to plaintiff, if no attorney is named above. A telephone call will not protect your rights; you must file and serve a written answer or motion (with fee of \$175.00 and completed Case Information Statement) if you want the court to hear your defense.

If you do not file and serve a written answer or motion within 35 days, the court may enter a judgment against you for the relief plaintiff demands, plus interest and costs of suit. If judgment is entered against you, the Sheriff may seize your money, wages or property to pay all or part of the judgment.

If you cannot afford an attorney, you may call the Legal Services office in the county where you live or the Legal Services of New Jersey Statewide Hotline at 1-888-LSNJ-LAW (1-888-576-5529). If you do not have an attorney and are not eligible for free legal assistance, you may obtain a referral to an attorney by calling one of the Lawyer Referral Services. A directory with contact information for local Legal Services Offices and Lawyer Referral Services is available in the Civil Division Management Office in the county listed above and online at http://www.njcourts.gov/forms/10153_deptyclerklawref.pdf.

s/ Michelle Smith

Clerk of the Superior Court

A True Copy
Attest:

Process Server
Sandra Yade

DATED: 08/02/2022

Name of Defendant to Be Served: Cigna Health and Life Insurance Company

Address of Defendant to Be Served: 900 Cottage Grove Road Bloomfield, CT 06002

MONMOUTH COUNTY
SUPERIOR COURT
PO BOX 1270
FREEHOLD

NJ 07728

TRACK ASSIGNMENT NOTICE

COURT TELEPHONE NO. (732) 358-8700
COURT HOURS 8:30 AM - 4:30 PM

DATE: JULY 29, 2022
RE: MONMOUTH COUNTY PAIN MANAGEME VS CIGNA HEALTH A
DOCKET: MON L -002063 22

THE ABOVE CASE HAS BEEN ASSIGNED TO: TRACK 2.

DISCOVERY IS 300 DAYS AND RUNS FROM THE FIRST ANSWER OR 90 DAYS
FROM SERVICE ON THE FIRST DEFENDANT, WHICHEVER COMES FIRST.

THE PRETRIAL JUDGE ASSIGNED IS: HON KATHLEEN A. SHEEDY

IF YOU HAVE ANY QUESTIONS, CONTACT TEAM 003
AT: (732) 358-8700 EXT 87871.

IF YOU BELIEVE THAT THE TRACK IS INAPPROPRIATE YOU MUST FILE A
CERTIFICATION OF GOOD CAUSE WITHIN 30 DAYS OF THE FILING OF YOUR PLEADING.
PLAINTIFF MUST SERVE COPIES OF THIS FORM ON ALL OTHER PARTIES IN ACCORDANCE
WITH R.4:5A-2.

ATTENTION:

ATT: LORI B. SHLIONSKY
CALLAGY LAW
650 FROM RD
STE 565
PARAMUS NJ 07652

ECOURTS

3. Venue and Jurisdiction is proper in the Monmouth County Superior Court because the Plaintiff resides in Monmouth County.

ANATOMY OF THE CLAIM

1. Upon information and belief, at all material times Principal had health insurance through her employer, Seton Hall University, which provided health insurance benefits via a group insurance contract administered by third-party Cigna Health and Life Insurance Company.

2. At the time of the subject surgery Principal's selected medical benefit option was the Open Access Plus Medical Benefits, OAP1. See **Exhibit A**.

3. Patient presented to the operating room of the Hudson Regional Hospital, located at 55 Meadowland Parkway, Secaucus, New Jersey 07094 on September 11, 2019, with severe radiating back and leg pain with neurologic claudication brought on by severe spinal stenosis at L3-L4, L4-L5, and L5-S1. See **Exhibit B**.

4. On September 11, 2019, Dr. Brian Bannister, medical provider with Monmouth County Pain Management, provided medically necessary and reasonable services to Patient. Id.

5. Patient underwent an L3 laminectomy, an L4 laminectomy, an L5 laminectomy and a partial S1 laminectomy on September 11, 2019. Id.

6. At the time of the subject surgical procedure, Dr. Brian Bannister, medical provider with Monmouth County Pain Management was not participating in the network of providers associated with the benefits provided by the plan. See **Exhibit C**.

7. The subject complex spinal surgery performed by the Out-of-Network provider Dr. Brian Bannister, medical provider with Monmouth County Pain Management, qualifies as a covered medical procedure pursuant to the terms of the Summary Plan Description (hereinafter "SPD"). See **Exhibit D**. (Page 19 of SPD).

8. The bill for this service, submitted to Defendant by way of health insurance claim forms (hereinafter “HICFs”), was \$200,900.00. See Exhibit E.

9. On April 2, 2020, Defendants allowed reimbursement for these surgical services rendered by Dr. Brian Bannister in the total amounts of \$623.88. See Exhibit C.

10. This represents an underpayment of approximately \$26,585.82, considering applicable pay rates.

11. The Plan’s SPD allows for reimbursement to out-of-network providers such as Dr. Brian Bannister of Monmouth County Pain Management pursuant to the Maximum Reimbursable Charge. See Exhibit D.

12. The SPD defines the Maximum Reimbursable Charge as:

The Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or

A policyholder selected percentage of a schedule developed by the Insurance Company that is based upon the methodology similar to the methodology utilized by Medicare to determine the allowable fee for the same or similar services within the geographic market. (The Insurance Company may apply a rate higher than the Medicare allowable rate.)

A Medicare based schedule will not be used in determining the Maximum Reimbursable charge for:

- Charges made by providers not participating in Medicare or that do not submit their Medicare ID with the claim;
- Covered Services which Medicare has not established a rate; and
- The following Covered Services until such time as the Insurance Company has implemented a Medicare-based schedule for them: certain ambulance services, treatment of end state renal disease, Home Health Care, Skilled Nursing Facility, and inpatient rehabilitation.

In these situations:

- The Maximum Reimbursable Charge is determined based on the lesser of:
 - The provider's normal charge for a similar service or supply; or
 - The 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company.

See Exhibit D (SPD at page 16).

13. The medical provider, Dr. Brian Bannister, of Monmouth County Pain Management did not submit a Medicare ID with the claim associated with the instant surgical procedure. See Exhibit E.

14. Because this claim was not submitted to Medicare or with any Medicare ID, the applicable pay rate for this claim is the "80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company." See Exhibit C.

15. Plaintiff disputes the calculation Defendant used to establish the allowed reimbursement for CPT codes 63048 (3 times), 63047 and 76000, wherein Defendant reimbursed Plaintiff \$75.50 (3 times) and \$397.38 and \$0, respectively, far below the Plan's reimbursement rate. See Exhibit C and Exhibit D at Page 16.

16. Plaintiff appealed Defendant's determination on multiple occasions.

17. In fact, pursuant to Defendant's correspondence of June 12, 2020, plaintiff has exhausted the appeals process. See Exhibit F.

18. Thus, Plaintiff has exhausted all administrative remedies.

19. Dr. Brian Bannister of Monmouth County Pain Management, proceeding on an Assignment of Benefits from Patient, brought suit.

20. Accordingly, Plaintiff brings this action for the recovery of the balance of benefits due to Principal under the Plan for the treatment rendered to him by Dr. Brian Bannister.

FIRST CAUSE OF ACTION
(Breach of Contract)

1. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

2. As a result of the foregoing, Defendants provide health insurance benefits to the insured Patient and through their actions breached the contract with the Patient.

3. As a result of Defendants actions, Plaintiff has been damaged in an amount of \$26,585.82 for date of service September 11, 2019, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

SECOND CAUSE OF ACTION
(Unjust Enrichment)

4. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

5. Defendant was unjustly enriched at the expense of the Plaintiff.

6. Plaintiff provided services to Patient, the Defendants insured, and the Plaintiff was underpaid pursuant to the health benefit plan.

7. As a direct and proximate result of the Defendant's actions and unjust enrichment, Plaintiff has suffered, and will continue to suffer, substantial monetary damages.

8. As a result of Defendants actions, Plaintiff has been damaged in an amount of \$26,585.82 for date of service September 11, 2019, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

THIRD CAUSE OF ACTION
(Promissory Estoppel)

9. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

10. Defendant made representations to Plaintiff concerning payment in accordance with the health benefit plan or Summary Plan Description ("SPD").

11. Defendant failed to comply with the terms of the Summary Plan Description.

12. Plaintiff reasonably relied upon the representations made by the SPD.

13. As a result of Defendants actions, Plaintiff has been damaged in an amount of \$26,585.82 for date of service September 11, 2019, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

FOURTH CAUSE OF ACTION
(Breach of Duty of Good Faith and Fair Dealing)

14. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

15. Defendants owed Plaintiff an obligation to act in good faith and deal fairly with him regarding the terms of the SPD.

16. By engaging in the misconduct alleged herein, Defendants breached their duty of good faith and fair dealing, which has damaged and continues to damage Plaintiff.

17. As a result of Defendants actions, Plaintiff has been damaged in an amount of \$26,585.82 for date of service September 11, 2019, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

WHEREFORE, Plaintiff demands judgment against Defendants, as follows:

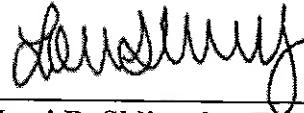
- a. For an Order directing Defendant to pay to Plaintiff \$26,585.82 for date of service (DOS);
- b. For compensatory damages and interest;
- c. For attorney's fees and costs of suit, if allowed by the Agreement; and
- d. For such other and further relief as the court may deem just and equitable.

[Signature block continued on next page.]

Dated: July 29, 2022

Respectfully submitted,

CALLAGY LAW, PC



Lori B. Shlionsky (Bar Id. 205322017)

650 From Road, Suite 240

Paramus, New Jersey 07652

Telephone: (201) 261-1700

Facsimile: (201) 549-6237

E-mail: lshlionsky@callagylaw.com

Attorney for Plaintiff

TRIAL COUNSEL DESIGNATION

Lori B. Shlionsky, Esq., is hereby designated as Trial Counsel in the above matter.

R. 4:5-1(b)(2) CERTIFICATION

Pursuant to R. 4:5-1(b)(2), I hereby certify that the matter in controversy is not the subject of any other action pending in any court, is not the subject of a pending arbitration proceeding and is not the subject of any other contemplated action or arbitration proceeding, except as may be set forth below:

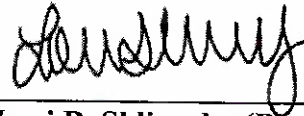
None.

I further certify that I know of no non-parties who should be joined in the action pursuant to R. 4:28, or who may be subject to joinder pursuant to R. 4:29-1(b) because of potential liability to any party on the basis of the same transactional facts, except as may be set forth below:

None.

Respectfully submitted,

CALLAGY LAW, PC



Lori B. Shlionsky (Bar Id. 205322017)

650 From Road, Suite 240

Paramus, New Jersey 07652

Telephone: (201) 261-1700

Facsimile: (201) 549-6237

E-mail: lshlionsky@callagylaw.com

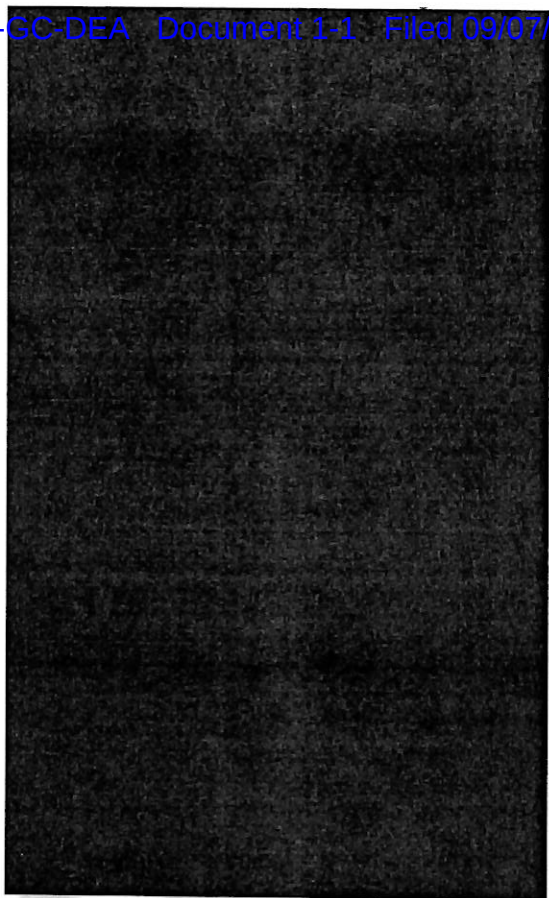
Attorney for Plaintiff

A True Copy
Attest: 

Process Server
Sandra Yade

Ignia Health and Life Insurance Co.

Coverage Effective Date: 01/01/2015



Ston Hall University

Insured



Network Savings Program

Open Access Plus

No Referral Required	
PCP Visit	\$20
Specialist	\$20
Inpatient Hosp	\$0
Hospital ER	\$75
Urgent Care	\$35
Network Coinsurance:	
In	100%/0%
Out	70%/30%

may be asked to present this card when you receive care. The card does not guarantee you must comply with all terms and conditions of the plan. Willful misuse of this card is considered a violation of the plan's terms and conditions.

PATIENT ADMISSION AND OUTPATIENT PROCEDURES:

Network provider must call the toll-free number listed below to pre-certify the above service to your plan documents for your pre-certification requirements. Failure to do so may affect your benefits. In an emergency, seek care immediately, then call your primary care doctor as soon as possible for further assistance and directions on follow-up care within 48 hours.

HINTS to:

P.O. Box 182223, Chattanooga, TN 37422-7223

Member Service/Network Provider Services: 1-800-244-6224

Encourage you to use a PCP as a valuable resource and personal health advocate.

AWAY FROM HOME

MEDICAL RECORD
STATUS: UNSIGNED

Progress Notes

NOTE DATED: 09/11/2019 12:34
LOCAL TITLE: OR: OPERATIVE REPORT
VISIT: 09/11/2019 08:33 SAME DAY SURGERY M

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Lumbar spinal stenosis.

POSTOPERATIVE DIAGNOSIS: Lumbar spinal stenosis.

PROCEDURES PERFORMED: L3 laminectomy, L4 laminectomy, L5 laminectomy, S1 partial laminectomy.

SURGEON: Joshua Rovner, MD

SURGICAL ASSISTANT: Brian Bannister, MD

ANESTHESIA: General endotracheal.

POSITION: Prone.

COMPLICATIONS: None.

CONDITION: Stable to PACU.

PREOPERATIVE INDICATIONS: Ms. Williams is a 63-year-old female with severe radiating back and leg pain with neurogenic claudication. She was found to have spinal stenosis at L3-4, L4-5 and L5-S1. She failed an extensive course of nonsurgical treatment and was indicated for the above procedure, which was deemed to be medically necessary. Risks, benefits, and alternatives of the procedure were discussed with this patient at length. Risks included, but not limited to, bleeding, infection, wound dehiscence, nerve damage, vascular damage, anesthesia complications, continued pain, paralysis and death. The patient understood the risks, benefits and alternatives, and agreed to undergo the above procedure.

DESCRIPTION OF THE PROCEDURE: On the date of surgery, the patient was seen and examined in the preop holding area. Risks, benefits, and alternatives were again discussed and consent was signed and witnessed. All questions were answered. No guarantees were given. The patient was subsequently brought into the operating room and placed supine on the stretcher. General endotracheal anesthesia was induced and begun without difficulty. IV antibiotics were given prior to incision. Next, the patient was placed prone on a Wilson frame. Eyes were protected. Arms were protected. All bony prominences were carefully padded. Low back was prepped and draped in a usual sterile fashion. Next, an incision was made from L3-4 to L5-S1. Careful dissection was made down to the lumbar fascia which was split in line with the incision. Subperiosteal dissection was made from L3 through S1 and deep retractors were placed. Next, Leksell rongeurs as well as high-speed burrs and Kerrison rongeurs were used to create a central laminectomy of L3.

** THIS NOTE CONTINUED ON NEXT PAGE **

MEDICAL RECORD
STATUS: UNSIGNED

Progress Notes

09/11/2019 12:34

** CONTINUED FROM PREVIOUS PAGE **

Bilateral subarticular decompressions were done also using a Kerrison rongeur removing the ligamentum flavum and decompressing bilateral nerve roots. Next, the exact same procedure was done at L4, the exact same procedure was done at L5 and the cranial portion of S1 was taken in a way of partial laminectomy of S1. Central decompression and bilateral subarticular and foraminal decompressions were done at all three levels L3-4, L4-5 and L5-S1. The dura was completely decompressed at this procedure. There was no evidence of dural tear or complications. There was no significant bleeding. A deep medium Hemovac drain was placed and 1 gm of vancomycin powder was placed in deep subcutaneous tissues as an antibiotic prophylaxis. Next, fascia was closed using interrupted Vicryl sutures and adipose as well as skin was closed in a multilayered fashion. The drain was placed to suction. Dermabond, Steri-Strips and clean dry sterile dressing were placed. The patient was placed supine and awoken from general endotracheal anesthesia in stable condition having tolerated the procedure well.

Postoperative plan will be for gentle activities as tolerated, pain control, early mobilization and close followup.

Joshua Kovner, MD

PTC/84

JOB: 0911-061

DDT: 09/11/2019 12:34

TDT: 09/12/2019 05:09

DRAFT COPY - DRAFT COPY -- ABOVE NOTE IS UNSIGNED-- DRAFT COPY - DRAFT COPY

Cigna Health and Life Insurance Company
 SCRANTON CLAIM OFFICE
 P.O. BOX 182223
 CHATTANOOGA TN 37422-7223

Cigna Health and Life Insurance Company

SETON HALL UNIVERSITY

Dr. Bannister
 (Asst.)



MONMOUTH CNTY PAIN MGMT
 432 OCEAN BLVD UNIT 201
 LONG BRANCH NJ 07740-5681

Date through which claims were processed:

04/02/2020

Payloc

768

How to Contact Us

☒ Mail to the return address in upper left corner of this page

☒ Phone: (800) 244-6224

Provider Explanation of Medical Payment

Understanding this Benefits Statement

This page provides a summary of the payments made this period.

The accompanying pages give more detail on the claims we processed for this period. Please review both the front and back of each page to see how the benefit amounts in the Provider Explanation of Medical Payment Report were determined.

In the event a claim is denied.....

Rights of Review and Appeal - For Physician or Health Care Provider

If you have questions or disagree with the payment identified on this Explanation of Medical Payment Report, you may ask to have it reviewed. If you have a contractual agreement with Cigna HealthCare, please refer to the procedural guidelines associated with your Cigna HealthCare contract, or call our office for assistance.

Federal Rights of Review and Appeal - For Employee

- Call Member Services at the toll free number on this Explanation of Benefits (EOB) or your ID card if you have questions regarding this EOB.
- If you're not satisfied with this coverage decision, you can start the Appeal process by submitting a written request to the address listed in your plan materials within 180 days of receipt of this EOB (unless a longer time is permitted by state law or your plan).
- Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. Contact Member Services if you need further instructions on how and where to send your request for review.
- Be sure to include your 1) Name, 2) Operation Location/Group Number, 3) Employee/Patient ID number, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.
- You are entitled to receive free upon request access to, and copies of, all documents, records and other information relevant to your claim for benefits.
- You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you also have the right to bring legal action under section 502(a) of ERISA following our review.

Payment Summary

Check Number: 00397878477	Check Amount: \$623.88	Check Date: 04/02/2020
---------------------------	------------------------	------------------------

G2434D 07-21-2017 PROCLAIM Medical Provider EOP

Detach on Perforation Below - Please Cash Promptly

Cigna Health and Life Insurance Company

SETON HALL UNIVERSITY

CHECK #

00397878477

73-27/421

DATE	Provider #
04/02/2020	464029458 0010

Pay Loc 768

SIX HUNDRED TWENTY THREE DOLLARS AND 88 CENTS

Pay MONMOUTH CNTY PAIN MGMT
 to the 432 OCEAN BLVD # 201
 Order LONG BRANCH NJ 07740-5681
 of

Dollars \$ *****623.88

Void If Not Cashed Within 180 Days

FIFTH THIRD BANK
 NORTHERN, KENTUCKY

3334085

G2434D 07-21-2017 PROCLAIM Medical Provider EOP

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK
 ON THE BACK. HOLD AT AN ANGLE TO VIEW.

00397878477 0421002721 7481590250



Provider Explanation of Medical Payment Report

Provider Number 464029458 0010		Provider Name HONMOUTH CNTY PAIN MGMT				Date through which claims were processed 04/02/2020				THIS IS NOT A BILL Retain for Your Records				Page 1.
Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/ Discount	Deduct/Copay Amount	Coinurance Amount	DRG / Per Diem / APC Type	DRG / Per Diem / APC Number	DRG/ Per Diem Benefit Amount	Plan Benefit	See: Note

Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.

1	09112019	63067		95000.00				397.38	94602.62		0.00	397.38	A0
2	09112019	63068		34500.00				75.50	34524.50		0.00	75.50	A0
3	09112019	63068		34500.00				75.50	34524.50		0.00	75.50	A0
4	09112019	63068		34500.00				75.50	34524.50		0.00	75.50	A0
5	09112019	76000	76000	2400.00				2400.00			0.00	0.00	A1
TOTAL				200900.00				623.88	200276.12		0.00	623.88	

THE \$500 OUT OF NETWORK INDIVIDUAL DEDUCTIBLE HAS BEEN SATISFIED FOR 2019
 THE \$2,000 OUT OF NETWORK INDIVIDUAL 'OUT-OF-POCKET LIMIT' HAS BEEN REACHED FOR 2019
 THE \$1,000 IN NETWORK INDIVIDUAL 'OUT-OF-POCKET LIMIT' HAS BEEN REACHED FOR 2019
 \$156,950.28 HAS BEEN APPLIED TO THE UNLIMITED ALL MEDICAL BENEFITS INDIVIDUAL LIFETIME MAXIMUM
 \$500.00 HAS BEEN APPLIED TOWARDS THE \$1,000 OUT OF NETWORK FAMILY DEDUCTIBLE FOR 2019
 \$2,000.00 HAS BEEN APPLIED TOWARDS THE \$4,750 OUT OF NETWORK FAMILY 'OUT-OF-POCKET LIMIT' FOR 2019

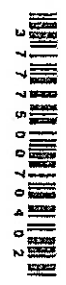
THE \$2,000 IN NETWORK FAMILY 'OUT-OF-POCKET LIMIT' HAS BEEN REACHED FOR 2019

PAYMENT OF \$623.88 TO HONMOUTH CNTY PAIN MGMT
 BALANCE..... \$197,876.12

VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.CO)

A0) FOR OUT-OF-NETWORK SERVICES, CIGNA WILL REIMBURSE YOU UP TO A SET MAXIMUM AMOUNT (KNOWN AS MAXIMUM REIMBURSABLE CHARGE IN YOUR PLAN BOOKLET). YOUR HEALTH CARE PROFESSIONAL MAY BILL YOU FOR ANYTHING ABOVE THIS AMOUNT.

A1) THE PROCEDURE IS DISALLOWED BECAUSE THIS SERVICE OR A COMPONENT OF THIS SERVICE WAS PREVIOUSLY BILLED BY ANOTHER HEALTH CARE PROFESSIONAL.



Seton Hall University

COURT REPORTING AND LITIGATION
DEPARTMENT

EFFECTIVE 10/1/2022 January 1, 2023



C78026

CLAUDE

This document printed on September 1, 2022. The following page of this document(s) previously printed to your school district's your district.

Printed on 9/1/22

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When You Have A Concern Or Complaint

Bellevue

Form 1099-C, 10/1/2019

Issued by: 10/1/2019

CIGNA HEALTH AND LIFE INSURANCE COMPANY

Cigna Company (hereinafter called "Cigna") certifies that it insures certain Employees for the term(s) specified by the following policy(ies):

PO: 01/01/2019 - 01/01/2020

GROUP POLICY(IES) - COVERAGE

CIGNA - 01/01/2019 - 01/01/2020 PLUS MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2019

THIS CERTIFICATE IS SUBJECT TO THE LAWS OF THE STATE OF NEW JERSEY

This certificate contains pre-admission certification and continued care review provisions. Benefits under this certificate may be reduced in the event of noncompliance with the requirements of these provisions.

This certificate describes the main features of the insurance. It does not contain or alter any of the terms of the policy(ies). If questions arise, the policy(ies) will govern.

This certificate sets the place of any other record or paper that describes the insurance.


Anne K. Smith, Corporate Vice President

Explanation of Terms

A will find terms starting with capital letters throughout your certificate. To help you understand some specific terms of this contract defined in the Definitions section of your certificate:

The Schedule:

The Schedule is a brief outline of your minimum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.



Local Plan Providers

When you select a Participating Provider, this Plan pays a set share of the costs that it covers under a Local Participating Provider. Participating Providers include Physicians, Hospitals, Ambulatory Health Care Providers and Other Health Care Entities. Consult your Provider's Guide for a list of participating providers in your area. Participating Providers committed to providing you and your dependent(s) programs and whole-person medical care.

Extra Available to Connection With Your Medical

The following pages describe helpful services available in connection with your medical plan. You can access these services by calling the toll-free number shown on the back of an ID card.

202

203

204

Case Management

Case Management is a service provided through a Review process, which results individually with treatment goals created beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care, the most effective setting possible, whether at home, in an outpatient, or an inpatient or a Hospital or specialized facility, and the most the Case Management team. A Case Management professional will work closely with the patient, or his family and the attending Physician to determine appropriate treatment options which will best meet the team's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to your patients and provide ongoing support for the family needs of medical issues.

Case Managers are Registered Nurses (RNs) and other licensed health care professionals, each trained in a wide variety of care such as chronic, high-risk pregnancies and cancer, surgery, mental health, rehabilitation, general illness and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or to dependent(s). In addition, Case Managers are supported by staff of Physician advisors who offer guidance regarding treatment options and medical decision-making. When the Case Manager recommends a treatment program, the patient's care will be coordinated with the patient's care and the patient's care will be coordinated with the patient's care.

1. You will be assigned to an attending Physician and a Case Management professional by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer's office or a dedicated review program may be available. The review of your condition may occur in conjunction with Case Management.

2. The Review Organization determines which case management services are appropriate.

3. You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary. No penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

4. Following an initial assessment, the Case Manager meets with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, to home medical care, or care of an extended Hospital care program). You are not permitted if the alternate treatment program is not followed.

5. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services at a Hospital bed and other Portable Medical Equipment for the home).

6. The Case Manager also acts as a liaison between the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).

7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

When participation in Case Management is strictly voluntary, Case Management professionals can offer guidance, coordinate treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a state of need.

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Important Notices

Notice of Grandfathered Plan Status

This plan is being treated as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care



A grandfathered health plan can provide or exclude health plan coverage that was already in effect when the law was enacted. Health plan grandfathering health plans describe that such coverage may not include certain consumer protections of the ACA that apply to other plans. For example, the requirement for the provision of preventive health services could not exist during. However, grandfathered health plans are exempt from certain other consumer protections of the ACA that are not. For example, the elimination of lifetime maximums.

Health plan rules which do not apply and which provisions do not apply to a grandfathered health plan and a health plan is plan to change from grandfathered health plan will be directed to the plan administrator of the new employer or address provided in your plan documents, to be reviewed or plan sponsor or its representatives can be found in your plan documents at:

[Access Cigna member resources, where you can find your plan is subject to ERISA. You may also contact the plan's Human Resources Administration, U.S. Department of Labor at 1-866-444-3212, at:](#)

[Grandfathered health plans.](#) This website has a table summarizing which provisions do and do not apply to grandfathered health plans.

Your plan is a grandfathered government plan or a health plan, a copy also contains the U.S. Department of Health and Human Services at [www.hhs.gov/gap](#).

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Instant Information

Mental Health Parity and Addiction Equity Act

A certificate is provided to assist below.

The event of a conflict between the provisions of your plan documents and the provisions of this statute, the provisions provide the better benefit shall apply.

Schedule and Mental Health and Substance Abuse related Expenses

and Hospitalization charges for Mental Health and Substance Abuse will be paid at the Outpatient level. Covered services are charged as follows:

Mental Health and Substance Abuse Services

Mental Health Services are services that are required or recommended that include the behavior, emotional, thinking or sight processes. In determining health plan's possible charges for the treatment of any psychological conditions related Mental Health will not be considered to be charges made. Insurance - Cigna Health

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind altering drugs that requires long-term care and results in behavioral changes. In the possible, charges made for the treatment of any psychological conditions related to substance abuse services are identical to drug abuse in addition will not be considered to be charges made for treatment of substance abuse.

Inpatient Mental Health Services

Services that are provided by a hospital when you are under dependent or confined in a hospital for the diagnosis and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Hospitalization, Emergency Services.

Mental Health Residential Treatment Services are services provided by a hospital for the evaluation and treatment of the psychological and social functioning. Treatments that are a result of substance Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social dysfunction that are the result of Mental Health conditions. provides a substance abuse and psychological treatment program, under the supervision of Physicians, provides 24 hour care, in which a person lives in an open setting, and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when admitted to a registered bed point in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services are services of services which are provided in your Mental Health when treatment is provided on an outpatient basis, while you or your dependent is not confined in a hospital, or in partial hospitalization program, and is provided in an individual, group or Mental Health treatment Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as anxiety or depression or other anxiety with daily functioning, emotional adjustment or concerns related to chronic conditions, such as personality or depression, personality conditions associated with mental problems, alcoholism, childhood adjustment problems or conduct disorder, adjustment disorder, anxiety or personality disorders or other mental disorders, or health administration of the Mental Health conditions (except intervention and major procedures) and outpatient testing and observation.

Partial Hospitalization Services are services that are provided for not less than 4 hours and not more than 12 hours in any 22 hour period.

Emergency Hospitalization versus Hospitalization Services

Services provided for stabilization while you or your dependent is confined in a hospital when covered for the



services and **medication** of abuse or addiction is alcohol and/or prescription Substances Abuse Services include Residential Outpatient Services.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and physical symptoms/conditions that are a result of substance Substances Abuse services.

Substance Abuse Residential Treatment Services are an inpatient or residential treatment of the treatment of psychological and physical symptoms that are the result of Substance Abuse services. Substance Abuse Residential Treatment Services include the supervision of Physician, provides 24-hour care, in which a person lives in an open setting, and is treated in accordance with the laws of the appropriate regulatory agency or residential treatment center.

person is considered confined in a Substance Abuse Residential Treatment Center when the person is a registered patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Substance Abuse Rehabilitation Services

services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, which may be provided in a Hospital, including outpatient treatment of an individual in a Substance Abuse Intensive Outpatient Therapy Program and the Partial Hospitalization Unit.

Partial Hospitalization services are services that are provided for less than 4 hours and are more than 4 hours in any 24-hour period.

Substance Abuse Intensive Outpatient Therapy Program consists of various levels or phases of treatment that are ordered by a certified/licensed Substance Abuse program, services Outpatient Therapy Programs provide a comprehensive individual, family and/or group therapy in a day setting (i.e., more than once a week).

Substance Abuse Detoxification Services

Detoxification and related medical auxiliary services are ordered when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on Medical Necessity of such situation, whether such services will be provided in an inpatient or outpatient setting.

Mental Health and Substance Abuse Evaluation

A following evaluation is hereby deleted and no longer part:

any other clinical diagnosis or diagnosis or any treatment or therapy ordered as a condition of service provision or condition of evaluation evaluation under Medical Necessity and otherwise covered under this policy or agreement.

Services within the requirements

The total number of the following services within your Certificate of Coverage is subject to change in accordance with the policy.

Visit Limits

Any health care services related to a Mental Health or Substance Abuse diagnosis will not incur a visit limit or a day limit but are limited to periods consisting and subsequent evaluation, assessment.

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Discrimination is Against the Law

Cigna complies with applicable Federal and state laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or individuals with specific conditions of race, color, national origin, age, disability or sex.

Cigna

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written communications in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services for people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that a claim has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACallCenter@cigna.com or by writing to the following address:

Cigna
 Health Insurance Company
 P.O. Box 10000
 Birmingham, AL 35202



you need assistance using a mobile phone, please call numbers on the back of your E-card or visit us online at www.cigna.com. For additional information, contact us with the U.S. Department of Health and Human Services, Office for Civil Rights, Complaint Form, available at www.hhs.gov/ocr/office/foia or by contacting the U.S. Department of Health and Human Services, 100 Independence Avenue, SW, Room 1001, 10000 Building, Washington, D.C. 20420. (1-800-368-1019, ext. 111) (TTY: 1-800-368-1019).

Important terms are available at www.cigna.com/terms.

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affinity of language assistance services

galeo - AFFIDAMENTO. I servizi di assistenza linguistica sono disponibili per tutti. Per saperne di più sui servizi Cigna, visitate il sito www.cigna.com o il numero di linea al vostro numero (1-800-368-1019) (TTY: 1-800-368-1019).

malay - ATIDAKTIF. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

italo - 注意 - 我門可為您免費提供翻譯協助服務。請向 Cigna 的聯絡客戶 - 服務電話 (1-800-368-1019) 查詢詳情。查詢詳情，請撥打 (1-800-368-1019)。

sinatano - KINATUN. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

seog - 주선 한국어를 사용하시는 고객 간에 이용 서비스를 무료로 제공하실 수 있습니다. 해당 Cigna 입찰안을 통해서만 더 나은 설명을 위한 전화상담으로 해결하십시오. 기타 다른 경우에는 1-800-368-1019 TTY 다이얼 111번으로 전화하십시오.

qalog - FAUHA. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

seog - KINATUN. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

afinity of language assistance services are available for all. For additional information, contact us with the U.S. Department of Health and Human Services, Office for Civil Rights, Complaint Form, available at www.hhs.gov/ocr/office/foia or by contacting the U.S. Department of Health and Human Services, 100 Independence Avenue, SW, Room 1001, 10000 Building, Washington, D.C. 20420. (1-800-368-1019, ext. 111) (TTY: 1-800-368-1019).

Arabic - أفيداء. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

French - AFFIDAMENTO. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

French - AFFIDAMENTO. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

Portuguese - AFFIDAMENTO. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

Polish - UWAGA. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

Arabic

Arabic - أفيداء. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

Italian - AFFIDAMENTO. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).

German - AFFIDAMENTO. Halu bantuan bahasa untuk anda. Kami menawarkan bantuan bahasa untuk anda. Untuk mengetahui lebih lanjut, kunjungi www.cigna.com atau hubungi kami di 1-800-368-1019 (TTY: 1-800-368-1019).



الرجاء إرسال هذا النموذج إلى: **Personnel (HR)**
 10000 Cigna Way, Suite 100, Houston, TX 77060
 أو إرساله إلى: **Personnel (HR)**
 10000 Cigna Way, Suite 100, Houston, TX 77060
 أو إرساله إلى: **Personnel (HR)**
 10000 Cigna Way, Suite 100, Houston, TX 77060

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Important Notice

We hereby warrant ourselves that you will not be held financially liable for payments to health care providers for any reason, at this required **co-payment**, contribution to deductibles, and the covered expenses, if Cigna fails to pay for the actual expenses for any reason.

Please read the conditions set in level of emergency care, when you are in a participating provider in the network, an accident or injury will be considered to you as if you are a deductible or had been treated by a preferred provider.

Statement of Rights of Insured Persons

I have the right to be provided with information concerning plan provisions and procedures regarding products, services, costs, appeals procedures and other information about the insurance and the plan provided.

I have the right to obtain a current directory of preferred vendors in the Cigna network upon request, including business and telephone numbers, and a listing of providers in groups covered persons who speak languages other than English.

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How To File Your Claim

For each payment for in-network care, first show your insurance card and pay your share of the cost. If any part of the cost is not paid to Cigna for reimbursement. Our network members can be submitted by the provider of the claim. It is not waiting to for the first claim. If the claim is not **submitted** on your behalf, you must send your request claim form and completed back to the claims address and to the claim form.

If you get the required claim form from the website failed from internet, you must call by calling Member Services on the toll-free number for your identification card.

CLAIM REMINDERS

- **BE SURE TO USE YOUR CLAIM REMINDER**
 CHECK TO BE SURE TO FILL IN ALL THE
 CHINA'S CLAIM FORMS ON WHEN YOU CALL
 YOUR CLAIMS CENTER.
- **YOUR REMINDER IS THE FIRST STEP TO YOUR
 REMINDER REMINDER REMINDER.**
- **YOUR CLAIMS CENTER WILL REMINDER YOU TO
 YOUR REMINDER REMINDER REMINDER.**
- **BE SURE TO FOLLOW THE CLAIMS CENTER LISTED
 ON THE BACK OF THE CLAIM FORMS CAREFULLY
 WHEN SUBMITTING A CLAIM FOR YOUR.**

Timely Filing of a Claim Procedure

Cigna will consider claims for coverage within one year after proof of loss is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be extended from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied. However, if proof of loss is not given in the time period stated in the **coverage**, the claim will not be considered nor extended if it is shown that proof of loss was given as soon as reasonably possible.

WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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Eligibility - Effective Date

Employee Enrollment

This plan is offered to you as an employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the date you complete the **waiting period** of:

- 90 days in all lines of eligible employment, and
- you are an eligible full-time or part-time employee, and
- you normally work at least 35 hours a week, and
- you get your required contribution.

If you were previously covered and your insurance cannot be reinstated, the **Waiting Period** is however waived upon 11.



or otherwise could because you were no longer employed as a member of Eligible Employees, you are not required to wait the waiting period if you again become a member of a new or Eligible Employees within one year after your former tenure.

Eligibility for Dependent Insurance

You will become eligible for Dependent Insurance on the date

- the day you become eligible for yourself, or
- the day you request your first Dependent.

Waiting Period

Active – Date of Hire

Nonmember & Staff – First day of the month following 90 days of employment

Member of Eligible Employees

an Employee, as reported to the insurance company by your employer

Active Date of Employee Insurance

You will become insured on the date you elect the insurance, signing an approved payroll deduction or enrollment form, applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, leaving your election, if you are in Active Service on that date. If you are not in Active Service on that date due to a health status

As Enrolled – Employees

You are a Law Enforcer if

you elect the insurance more than 30 days after you become eligible, or

you request it after you request your payroll deduction (if required).

Dependent Insurance

If your Dependents to be insured, you will have to pay the total contribution, if any, toward the cost of Dependent Insurance.

Active Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents elected will be included.

All Dependents will be insured only if you are insured.

Law Enforcer – Dependents

You are a Law Enforcer for Dependent Insurance if

- you elect that insurance more than 30 days after you become eligible for it, or
- you request it after you request your payroll deduction (if required).

Exception for Newborns

All Dependents child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect insurance, your newborn child within such 31 days, coverage for that child will end on the 31st day. No matter the dependent insured toward the 31st day will be payable.

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Important Information About Your Medical Plan

Details of your medical benefits are described on the following page.

Opportunity to Select a Primary Care Physician

Choosing Primary Care Physicians

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Nevertheless, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Choosing Primary Care Physicians

You must request a transfer from one Primary Care Physician to another by completing an in the appropriate service request form (see ID card). Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.



addition, if we may have a secondary source of information relevant to a Participating Provider, we may seek ~~Dependent~~ will be used for the purpose of selecting a new Patient's care plan of treatment.

and

and

and



Open Access Plan Medical Benefits The Schedule

Part A you and Your Dependents

Open Access Plan Medical Benefits provide coverage for care in Network and Out-of-Network. Dependents shown below. Your Medical Benefits you and your Dependents may be required to pay a portion of the covered charges for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

Coverage is subject to limits on the Network Provider to your area with each provider area with a network provider that is covered under this plan. The number on the back of your ID card will indicate whether you are in the Network Provider coverage. If you choose out-of-network for services provided by a non-network provider, coverage for those services will be provided at the Out-of-Network benefit level.

Coinsurance

The term Coinsurance shows the percentage of charges for Covered Expenses that are covered and not required to you under the plan.

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are also amounts to be paid by you or your Dependent. Deductible amounts are separate from and not reduced for Copayments. Copayments and Deductibles are in addition to any Copayments. Once the Deductible maximums in The Schedule has been reached, you and your family may not qualify for further medical deductibles for the rest of that year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred in Network and Out-of-Network charges that are not paid by the Plan or plan because of any:

a. coinsurance, Copayments or Deductibles

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses as set out in:

- non-compliance penalties
- provider charges in excess of the Maximum Reasonable Charge

When the Out-of-Pocket Maximum shown in The Schedule is reached, Extra and Deductible benefits are provided at 100% coverage for:

- non-compliance penalties
- provider charges in excess of the Maximum Reasonable Charge

Accumulation of Plan Out-of-Pocket Maximum

Out-of-Pocket Maximums will reset annually. That is, in Network and Out-of-Network charges that are not paid by the Plan or plan because of any: a. coinsurance, Copayments or Deductibles. All other plan maximums and other specific maximums (e.g., non-compliance) will reset immediately following the end of the Out-of-Pocket calendar year.

Telehealth Services

Telehealth services provided during the reporting period result in payment reduction of 10% to the member's account (e.g., the member's deductible is paid to any other company).



Open Access Plus Medical Benefits The Schedule

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Open Access Plus Medical Benefits Policies. For purposes of this limitation, allowable charges shall be amount payable to the surgeon prior to any reductions due to co-insurance or deductible amount.

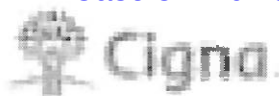
Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Open Access Plus Medical Benefits Policies.

DESCRIPTION	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays Note: "No charge" means no insured person is not required to pay Copayment	100%	70%



MAXIMUM RESPONSIBILITY	IN-NETWORK	OUT-OF-NETWORK
<p>Maximum Responsibility Charge Maximum Responsibility Charge is determined based on the level of the provider's actual charge for a service or supply as follows:</p> <p>A provider's actual percentage of a schedule developed by the Insurance Company that is based upon a methodology similar to the methodology utilized by Medicare to determine the allowable fee for the rates of similar services within the geographic market of the Insurance Company may apply a rate higher than the Medicare allowable rate.</p> <p>A Medicare-based schedule will not be used in determining the Maximum Responsibility Charge for:</p> <ul style="list-style-type: none"> a. charges made by providers not participating in Medicare or that do not submit their Medicare ID with the claim; b. Covered Services for which Medicare has not established a payment; c. the following Covered Services and such rate as the Insurance Company has implemented a Medicare-based schedule for these services: ambulatory services, treatment of old skin, renal disease, Home Health Care, Skilled Nursing Facility, and organ transplant. <p>In these situations:</p> <ul style="list-style-type: none"> a. the Maximum Responsibility Charge is determined based on the level of: <ul style="list-style-type: none"> i. the provider's actual charge for a service or supply as follows: ii. the 40th percentile of charges made by providers of such service or supply in the geographic area where it is provided as compared to a database selected by the Insurance Company. 	<p>See Appendix</p>	<p>200%</p>



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Stay</p> <p>The new Aflac Care plan has the difference between the provider's actual charges and the Maximum Allowable Charge, in addition to payment of deductibles, copayments and coinsurance.</p>		
<p>Calendar Year Deductible</p> <p>Individual</p> <p>Family Maximum</p> <p>Family Maximum Calculation Individual Calculation:</p> <p>Family maximums cover only those individual deductibles and then those amounts will be covered under the plan maximum. If the family deductible has been met prior to that individual deductible being met, then amount will be paid at the plan maximum.</p>	<p>Not Applicable</p> <p>Not Applicable</p>	<p>\$1,000 per person</p> <p>\$1,000 per family</p>
<p>Out-of-Pocket Maximum</p> <p>Individual</p> <p>Family Maximum</p> <p>Family Maximum Calculation Individual Calculation:</p> <p>Family maximums cover only those individual Out of Pockets and then those amounts will be covered at 100% of the family Out of Pocket has been met prior to that individual Out of Pockets being met, then amount will be paid at 100%.</p>	<p>\$1,000 per person</p> <p>\$1,000 per family</p>	<p>\$1,000 per person</p> <p>\$1,750 per family</p>



IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Physician's Services Primary Care Physician's Office Visits Specialty Care Physician's Office Visits Consultation and Referral Physician's Services Note: OFFICE procedures will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company Surgery Performed in the Physician's Office Second Opinion Consultations (provided on a voluntary basis) Allergy Immunizations Allergy Screen (diagnosed by the Physician in the office)	No charge after 10% per office visit copay No charge after 10% Specialist per office visit copay No charge after the 10% PCP or 10% Specialist per office visit copay No charge No charge after either the 10% PCP or 10% Specialist per office visit copay or the initial charge, whichever is less No charge	10% after plan deductible 10% after plan deductible No charge No charge 10% after plan deductible 10% after plan deductible
Preventive Care (according to USPSTF recommendations) - all ages <ul style="list-style-type: none"> • Individual counseling for lipid disorder • Immunizations (including lead poisoning screening for children, annual follow-up care and treatment) and physical examinations • Environmental and infectious screenings • Alcohol misuse and tobacco use counseling with patients • Tobacco use screening of adults and tobacco cessation interventions 	No charge	10% after plan deductible
Menstrual Care, PMS, PAF Screen Contraceptive Care Related Services (i.e., include treatment) Contraceptive Related Services (i.e., birth control)	No charge No charge for the contraceptive & birth control services	10% after plan deductible 10% after plan deductible



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU, CCU)	100% Limited to the most appropriate room appropriate rate Limited to the most appropriate room appropriate rate Limited to the appropriate rate	70% after plan deductible Limited to the most appropriate room rate Limited to the most appropriate room rate Limited to the HMO, PPO, or other room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedure Room, Treatment Room, and Observation Room	100%	70% after plan deductible
Inpatient Hospital Physician's Office Consultations	100%	70% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%	70% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%	70% after plan deductible



EMERGENCY AND URGENT CARE SERVICES	2021-2022 RATES	2022-2023 RATES
Emergency and Urgent Care Services Physician Office Visit Internal Emergency Room Emergency Department Services (including pathology and X-ray services) Urgent Care Facility or Dispensary Facility X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed to the facility as part of the E.R./U.C. visit) Independent X-ray and/or Lab Facility in conjunction with an E.R. visit Advanced Radiological Imaging (e.g. MRI, MRA, A & I, Ultrasound, PET, Scans etc.) Ambulance	No change after the 2021 PIP or 2021 Specialized prior review request No change after 15% prior review request* *maximum of adjustment No change No change after 20% prior review request* *maximum of adjustment No change No change No change No change 100%	No change after the 2021 PIP or 2021 Specialized prior review request No change after 15% prior review request* *maximum of adjustment No change No change after 20% prior review request* *maximum of adjustment No change No change No change 100%
Inpatient Services at Inpatient Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximums All have contracted	100%	100% after prior authorization
Laboratory and Radiology Services (includes pre-admission testing) Physician Office Visit Outpatient Hospital Facility Independent X-ray and/or Lab Facility	No change after the 2021 PIP or 2021 Specialized prior review request 100% 100%	100% after prior authorization 100% after prior authorization 100% after prior authorization



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Biotechnology Imaging (i.e. MRI, MRA, CAT Scans and PET Scans) Physician's Office Visit Hospital Facility Outpatient Imaging	No charge 100% 100%	70% after plan deductible 70% after plan deductible 70% after plan deductible
Outpatient Short Term Rehabilitation Therapy Calendar Year Maximum: 60 days for all therapies combined including: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Note: The Short Term Rehabilitation Therapy maximum does not apply to the treatment of autism.	No charge after the 100 P.D. or 100 days after per calendar year capex Note: Outpatient Short Term Rehab requires approval, regardless of plan or network, including the benefit.	70% after plan deductible
Chiropractic Care Calendar Year Maximum: 10 days Physician's Office Visit	No charge after the 100 P.D. or 100 days after per calendar year capex	70% after plan deductible
Home Health Care Calendar Year Maximum: 100 days (includes outpatient per visit nursing when approved as medically necessary)	100%	70% after plan deductible
Hospital Hospital Services Outpatient Services Home Management Unit as Home Health Care	100% 100%	70% after plan deductible 70% after plan deductible



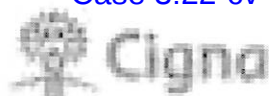
IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Bereavement Counseling Services provided as part of bereavement care Inpatient Outpatient Services provided to Member Family Members	100% 100% Covered under Member Health Benefit	100% after plan deductible 100% after plan deductible Covered under Member Health Benefit
Maternity Care Services Initial Visit to Confirm Pregnancy Note: OB/GYN providers will be considered either as a PCP or Specialist depending on how the provider contracts with the insurance Company All subsequent Prenatal Visits Postnatal Visits and Placental & Delivery Charges (i.e. global maternity fee) Physician's Office Visits & services to the global maternity fee when performed by an OB/GYN or Specialist Delivery - Facility (Hospital, Hospital, Birth Center)	No charge after the \$10 PCT or \$10 Specialist per office visit copay 100% No charge after the \$10 PCT or \$10 Specialist per office visit copay 100%	100% after plan deductible 100% after plan deductible 100% after plan deductible 100% after plan deductible
Abortion Includes only non-surgical procedures Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	No charge after the \$10 PCT or \$10 Specialist per office visit copay 100% 100% 100%	100% after plan deductible 100% after plan deductible 100% after plan deductible 100% after plan deductible



BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
<p>Family Planning Services</p> <p>Physician's Office Visit (Gynecology)</p> <p>Screening:</p> <p>The required benefits will include coverage for contraceptive devices (e.g., birth control and intrauterine devices (IUDs)) as well as services such as a pelvic exam. Coverage for other services covered when services are provided in the physician's office.</p> <p>Excludes:</p> <p>Reproductive Procedures for Gendered Label Legislation</p>	<p>No charge after the EOB PCT or EOB Reimbursement per office visit copay.</p>	<p>40% after plan deductible.</p>
<p>Infertility Treatment</p> <p>Coverage will be provided for the following services:</p> <ul style="list-style-type: none"> • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Laboratory and/or procedures performed specifically to correct fertility (e.g., procedures to correct an infertility condition). <p>Excludes:</p> <p>Coverage will not be provided for the following services, which do not correct fertility or correct an infertility condition:</p> <ul style="list-style-type: none"> • Artificial Insemination, In-vitro, ZIFT, Embryo Transfer, Intracytoplasmic Sperm Injection. 		
<p>Physician's Office Visit (Lab and Radiology Tests, Counseling)</p> <p>Insurance Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>No charge after the EOB PCT or EOB Reimbursement per office visit copay.</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>40% after plan deductible</p> <p>40% after plan deductible</p> <p>40% after plan deductible</p> <p>40% after plan deductible</p>



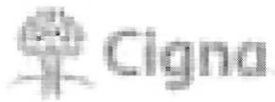
IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Organ Transplants Includes all medically appropriate non-experimental transplants Physician's Office Visit Inpatient Facility Physician's Services Lifetime Travel Maximum: Unlimited	No charge after the \$10,000 or \$20,000 Specialist per office visit copay 100% at Inpatient facility (deductible) 100% 100% at Lifetime travel maximum (deductible) 100% No charge	70% after plan deductible 70% after plan deductible 70% after plan deductible up to specific organ transplant destination Heart - \$100,000 Liver - \$250,000 Brain/Marrow - \$150,000 Heart/Lung - \$150,000 Lung - \$150,000 Pancreas - \$50,000 Kidney - \$50,000 Kidney/Pancreas - \$50,000 No charge
Durable Medical Equipment Calculate Your Maximum: Unlimited	100%	70% after plan deductible
External Prosthetic Appliances Calculate Your Maximum: Unlimited	No charge	70% after plan deductible
Hearing Aid Maximum One hearing aid for each hearing impaired ear every 24 months for a dependent child under age 18		
Durable Equipment Calculate Your Maximum: Unlimited	100%	70% after plan deductible
Nutritional Evaluation Calculate Your Maximum: 1 visit per person per year, the 1 visit limit will not apply to treatment of diabetes Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	No charge after the \$10,000 or \$20,000 Specialist per office visit copay 100% 100% 100%	70% after plan deductible 70% after plan deductible 70% after plan deductible 70% after plan deductible



DENTAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Dental Care Covered services are subject to a maximum of 1 dental treatment covered within a calendar year except for second, natural teeth. Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	No charge after the \$100 POF or \$250 specified per office visit copay. 100% 100% 100%	70% after plan deductible 70% after plan deductible 70% after plan deductible 70% after plan deductible
Identify/Resect/Reconstruct Surgery Note: Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Exclusions Not Covered and General Limitations" section of the certificate. Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services Surgical Procedures, Inpatient Outpatient Maximum \$10,000 Note: • Includes charges for surgical only. Does not include radiological services, consult, etc. • Does not pertain to the use of Pocket Maxillary • 100% included after plan deductible in the network	No charge after the \$100 POF or \$250 specified per office visit copay. 100% 100% 100%	70% after plan deductible 70% after plan deductible 70% after plan deductible 70% after plan deductible
Routine Foot Disorders	First covered charge for services associated with foot care for diabetes and associated vascular disease when Medically Necessary	First covered charge for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary
Treatment Resulting From Life-Threatening Emergencies Medical treatment required as a result of an emergency, such as a heart attack, stroke, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be considered a dental or medical expense is determined based on the medical necessity determination by the provider. Coverage for services rendered with the emergency related services shall be provided.		



MEMBER BENEFITS	IN-NETWORK	OUT-OF-STATE
Mental Health Inpatient Outpatient (includes Individual, Group and Intensive Outpatient) Psychiatrist & Clinical Nurse Outpatient Facility	100% \$15 per visit copay 100%	100% after plan deductible 100% after plan deductible 100% after plan deductible
Substance Abuse Inpatient Outpatient (includes Individual and Intensive Outpatient) Psychiatrist & Clinical Nurse Outpatient Facility	100% \$15 per visit copay 100%	100% after plan deductible 100% after plan deductible 100% after plan deductible



pen Access Plus Medical Benefits

Certification Requirements – Out of Network

a. You and Your Dependents

i. Admitted Critical Care/Contract Care Rates for Hospital Confinement

i. Admitted Critical Care (PAC) and Confinement Rate (CCR) rates are the per diem used to verify the Medical necessity and length of a Hospital Confinement while you or a Dependent require treatment in a Hospital.

As a registered bed patient, average for 48/48 hour intensive care.

For a Partial Hospitalization for the treatment of Mental Health or Substance Abuse.

For Mental Health or Substance Abuse Residential Treatment Services.

a. your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the care Organization by the end of the first scheduled work day after the admission or as soon as reasonably possible. For admission due to pregnancy, you should call the Bureau organization by the end of the third month of pregnancy. CCR could be requested, prior to the end of the certified length of stay for continued Hospital Confinement. The medical chart will be communicated to you, the attending Physician and Cigna.

covered Expenses incurred will be reduced by 50% for charges made for each separate admission to the acute care PAC is covered prior to the date of admission, or in the case of an emergency admission, by the 4th of the first scheduled work day after the date of admission. Payment provided after this deadline will be accepted if the penalty waived, provided notification was made as soon as reasonably possible.

covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed here will be reduced by 50%.

Hospital charges for first and second non-emergency visit above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CCR, and

any Hospital charges for treatment listed above for which PAC was requested but which were not certified as Medically Necessary.

i. any CCR are performed through a voluntary review first by a Bureau Organization with which Cigna has contracted.

In any case, these expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements – Out of Network

Outpatient Certification refers to the process used to verify the Medical Necessity of outpatient diagnostic testing and procedure, including, but not limited to those listed in this section, when performed at an outpatient or a free-standing Outpatient Facility, Outpatient Care Facility or a Physician's Office. You or your Dependent should call the toll-free number on the back of your ID card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedure. The results of the review will be communicated to you, the attending Physician and Cigna within 14 days of the Bureau Organization having received the request for certification. Outpatient Certification is performed through a utilization review process by a Bureau Organization with which Cigna has contracted. Outpatient Certification should only be requested for non-emergency procedure or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or procedure performed under Outpatient Certification is requested prior to the date the testing or procedure is performed.

covered Expenses incurred will be reduced by 50% for charges made for outpatient diagnostic testing or procedure for which Outpatient Certification was performed, but which was not certified as Medically Necessary.

In any case, these expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

(including, but not limited to:

- Advanced intra-spiral imaging – CT scans, MRI, MRA, PET scans
- Electrophysiology

or any

11/1

11/1



for Authorizations Prior to Authorization

Covered Plans Authorizations include the approval of the following services, when received from the Member, practitioner, prior to services being rendered, in order for said services and benefits to be covered under this policy, unless that request from Authorizations is already Medically necessary to be considered a Covered Expense, and/or that is classified as:

urgent Hospital services, except for all the following categories:

urgent services when participating with Health Care Facility

ambulatory treatment

outpatient facility services

ambulatory treatment programs

offered radiological imaging

non-emergent procedures or

transplant services

that:

or

or

covered Expenses

A term Covered Expense means the expenses incurred by or behalf of a person for the charges listed below if they are not after the insurance incurred for other benefits. Expenses paid for such charges are considered Covered Expenses to extent that the amount of expense provided are recommended by a Physician, and are Medically Necessary. The care and treatment of an injury or a sickness, as required by Cigna, and dependent's dependent's condition or injury or illness in the following:

covered Expenses

charges made to a Hospital, on its own behalf, for first and second and after necessary services and supplies, except that the any day of Hospital confinement is covered. Expenses will not include the portion of charges for first and second which is more than the first and second listed above in The Schedule.

charges for covered maintenance services, as from the active Hospital when the active maintenance and treatment can be provided.

charges made by a Hospital, on its own behalf, for special care and treatment, such as an observation.

charges made by a non-participating Hospital Facility, on its own behalf for medical care and treatment.

- charges made on its own behalf, by any other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute Inpatient, including care and treatment, except that the any day of Hospital Care Facility confinement. Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Care Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a First-aided or professional services.
- charges made by a Nurse, other than a certified or non-family or your dependent's family, for professional nursing services.
- charges made for observation and tests, including radiologic, diagnostic X-ray and laboratory examinations, x-ray, radiology, and laboratory services, treatment, observation, blood transfusions, organ and other tests and their administration.
- charges made for a baseline mammogram for women between the ages of 35 and 40, an annual mammogram for women age 40 and over, and mammogram at any time is ordered by a woman's health care provider for women with a family history of breast cancer or other breast cancer risk factors.
- charges made for an annual Pap smears, laboratory screening for Pap smear coverage includes an annual pap smear and any confirmatory test, when directed by physician, as ordered by the attending Physician, including all associated laboratory tests.
- charges made for an annual prostate-specific antigen test (PSA), including a digital rectal examination, for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, vaccine, injections in accordance with generally accepted medical practice, other medical services, prescriptions and counseling on contraceptive, emergency or other reproductive, other appropriate counseling, medical services, consistent with state or therapeutic in the following circumstances:
- abortion when a Physician certifies or certifies that the pregnancy would endanger the life of the mother, or where the expenses are incurred to treat medical complications after an abortion.

1) to determine whether or not we have in effect a change of "A" in "B" as the current representation of the formal theory *Formal Theory* (Unit 1, Form

- Major taxa of foraminifera last consisting of the following benthic and agglutinated and various deep-sea assemblages in a Permian, as keeping with prevailing current knowledge.

- necessary for which benefits are efficient provided under the standard Hamiltonian system.
- necessary for which benefits are not provided according to the 1-coupling that is proved system.

Notably, a limited type of surveillance may be authorized and conducted by the relevant law enforcement agencies in accordance with the relevant provisions of the Communications Act of 1934. Unlike the National Security Agency and the Federal Bureau of Investigation, the Department of Health and Human Services Department of Health and Human Services does not have a Department of Health and Human Services. Any independent child during that period of time may be authorized to perform such activities as may be authorized by the relevant law enforcement agencies.

- 100



approved by the Food and Drug Administration (FDA). Such drug must be injected, purchased in a single-dose unit individually appropriate for that specific condition, is one of the following efficient components: the American Medical Association Drug Formulary, the American Hospital Association Drug Formulary, the American Hospital Association Inpatient Drug Information, the United States Pharmacopoeia Drug Information, or it is recommended by a clinical study or review which is a peer-reviewed professional journal, and the drug has not been recommended by the FDA for the use prescribed.

charges for insulin, insulin syringes, penfilled insulin cartridges for the blood, glucose test strips, insulin reading strips and urine test strips, lancets, alcohol swabs and oral blood sugar control agents which are recommended or prescribed by a physician, when purchased in standard order quantities for the treatment of diabetes. Insulin pharmacokinetics are payable at the same frequency and C-coverage as any other Covered Expense.

charges for blood glucose monitors (including treatment for the blood), insulin pumps, infusion devices and related accessories. Charges for these items are not subject to the Flexible Medical Dependent Maximum shown on the Schedule.

charges for the diagnosis and treatment of autism and other developmental disabilities.

For a primary diagnosis of autism or another developmental disability, Cigna provides coverage for the following medically necessary therapies as prescribed through a treatment plan:

- occupational therapy where occupational therapy refers to treatment to develop a covered person's ability to perform the ordinary tasks of daily living;
- physical therapy where physical therapy refers to treatment to develop a covered person's physical function; and
- speech therapy where speech therapy speech therapy refers to treatment of a speech impairment.

If a covered person's primary diagnosis is autism, and the covered person is under 22 years of age, in addition to coverage for the therapy services as described above, Cigna also covers Medicaid's Medicaid's behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs as prescribed through a treatment plan. Except as stated below, such coverage of medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs is subject to a \$15,000 maximum benefit per calendar year for each year through 2011. Thereafter, the maximum benefit shall be adjusted by New Jersey regulations.

WORK-ANY-OR-MEDICATIONAL-INTERVENTION BENEFIT IS A COVERED PROGRAM BENEFIT AS AN OUT-OF-NETWORK COVERED-CHARGE WILL BE PAID FOR THE WORK-ANY-OR-MEDICATIONAL-INTERVENTION BENEFIT.

Exception: If the Employee providing coverage under the Contract is located in the Federal or a foreign country in which health and substance use disorder benefits are not provided, the maximum benefit does not apply.

The treatment plan is subject to review upon the request of the treating physician, and must include a diagnosis, proposed treatment by type, frequency and location, the anticipated outcome stated in goals, and the frequency by which the treatment plan will be updated. Cigna may request additional information as necessary to determine the coverage under the plan. Cigna may require the submission of an updated treatment plan once every six months unless Cigna and the treating physician agree to more frequent updates.

- charges made for surgical or neurosurgical treatment of Temporomandibular Joint Dysfunction.

Clinical Trials

Charges made for clinical patient services associated with cancer clinical trials approved and sponsored by the Federal government. In addition, the following criteria must be met:

- the cancer clinical trial is listed on the NIH website www.clinicaltrials.gov as being sponsored by the Federal government;
- the trial investigates a treatment for treatment cancer and the person has failed standard therapies for the disease, cancer, where standard therapies for the disease, or an effective non-pharmaceutical treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial, and is not treated "off protocol";
- the trial is approved by the Institutional Review Board of the institution administering the treatment.

Cancer patient services do not include, and reimbursement will not be provided for:

- the experimental service or supply itself;
- services or supplies used before or after the trial;
- services or supplies related to data collection for the clinical trial (e.g., laboratory-related costs);
- services or supplies which, in the absence of patient health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, food or service supplied by pharmaceutical and not yet FDA approved, without charge to the trial participant).



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a girl made her parents believe that she was a prostitute, coming
there for the same reasons as prostitutes, but in a more subtle
way. In the future, we should study it.

a person has completed in regard to a previously limited alternative device.

It has been demonstrated that a person is at risk for cancer when he is exposed to an ionizing source, government involvement is indicated. In 1970 and in the following years, a government-backed initiative was launched to encourage the use of radiation in the treatment of cancer.

The findings of the program are to identify specific practice patterns that have been demonstrated in the existing peer-reviewed evidence-based literature literature to identify original treatment options.

A developmental genetic history, genetic diagnosis prior to boys transfer, is provided when either parent has an initial diagnosis or a documented history of a psychiatric and/or substance abuse.

sexual reproduction is covered if a person is undergoing physical genital healing, or if a person has a ~~physical~~ sexual part as a permanent/continuous (or primary) feature. Healing is limited to 7 years per calendar year for each physical genital healing.

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agrees made the contract and construction and existing when it is a part of the contract of assignment of a debentured and signed

Fast and Frictionless Virtual Negotiation

major results for bilinear pseudodifferential operators that
 value preservation or conserving internal functional suggests
 multifunctional body parts are conserved. Additionally,
 common signal transduction or regulation of a conserved
 pathway is also conserved.

estimated for C_{org} = 100 mg C m⁻²

major modification to the design necessary, provided an efficient method of diagnosis has been made by a Professional Engineer, then available.

average for an average accounting rate of 1.0% per year. The average for a firm that had a positive return on investment was 1.0% per year. The average for a firm that had a negative return on investment was 1.0% per year. The average for a firm that had a return on investment of 1.0% per year was 1.0% per year.

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1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 26

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A comprehensive review of the literature is provided.

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Diabetes mellitus will also contribute to alcohol and tobacco use self-management training and more gradually to a decrease in a certified diabetes educator, as by a long-term strategy, as qualified to provide management education for diabetes.

1. according to standards of conventional studies (see below);
2. comparison of HbA_{1c} and fasting glucose in the population with
symptoms of diabetes; or

where a Fluctuation indicates that a change in soil composition is recorded due to a change in vegetation or conditions, or that soil conditions change as a result of disturbance.

Forward scanning will also include multiple checks for a forward, verified departure on passenger and crew for reported and certified as being paid passengers for a flight.

Source: U.S. Census Bureau, *Marriage, Divorce, Remarriage in the 1990s*, Washington, D.C., 1995.

Covered Expenses will include expenses incurred for charges made for a medical surgical system of treatment of an injury or a Sickness, you or any one of your Dependents, while covered for three months and prior to the expiration of an Elective Surgical Procedure recommended by a surgeon who has no opinion from another Physician who is qualified to diagnose and treat that injury or Sickness. Covered Expenses will also include any diagnostic laboratory or x-ray examinations asked for by the Physician who gives the opinion.

Prayers will be made at the end of the program.

World Heritage Site *See* **World Heritage Site**

It was shown that operators have no control over the number of messages that are sent to the gateway. Therefore it is not possible to control the number of messages that are sent to the gateway.

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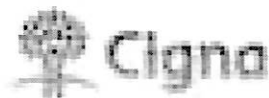
The payment will be made for a period of 10 years, as follows:

6. *unpublished by the author* (original: *Unpublished by the author*).

✶ Under Tropical Frontiers Ltd are conducted weekly and in a pleasant setting, where no previous and language requirements of students of foreign language.

1. The respondent considered the following information relevant to the question:

8. *Journal of the American Medical Association*, 1997; 277: 1033-1038.



procedure will be made under any other method to the extent a benefit is payable for surgical treatment under this Act.

Active Surgical Procedure

A **Active Surgical Procedure** means a surgical service which is not considered emergency in nature and which may be avoided without undue risk to the individual.

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Active Treatment

Active Treatment for medical and surgical services for the treatment or control of clinically severe (medically obesity as defined below) and if the services are demonstrated, through existing peer reviewed evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (medically obesity as defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:

- a. medical and surgical services to treat appearance or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (medically obesity) and
- b. weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

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Chaperone Surgeon

Chaperone Surgeon is any or any of a series (oral delivery or assignment) that demonstrates above can not be provided.

- a. the delivery or assignment is accompanied by a demonstrated clinically significant functional impairment and there is a reasonable expectation that the procedure will result in meaningful functional improvement or
- b. the chaperone surgeon is medically necessary as a result of injury, trauma, illness, or
- c. the chaperone surgeon is performed prior to age 18 and is required as a result of severe congenital facial deformity or congenital conditions.

Request or delivery of orthognathic surgery for the major condition are covered only when the previous orthognathic surgery and the above requirements, and there is a high probability of a permanent additional gap between or distortion of the articulation of jaw (occlusion).

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Home Health Services

- a. changes made to Home Health services under the terms of a Home Health Care Plan implemented within 14 days after the date Home Health Care begins.

Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. It must not be a place or a place where is dependent upon others for assistance over major activities of daily living (e.g., bathing, eating, toileting). Home Health Services will be provided for you only during times when there is a family member or caregiver present in the home to assist your essential care and/or essential services needs.

Home Health Services include:

- a. part time or intermittent services, and full time or 24-hour services that are needed on a short-term basis, including nursing care for or under the supervision of an Active Health Care Professional;
- b. physical, occupational or speech therapy;
- c. medical social work;
- d. nutrition services;
- e. medical supplies, appliances and equipment, drugs and medication lawfully dispensed only on the written prescription of a Physician, laboratory services, special meals, home infusion therapy and any diagnostic and therapeutic services, including surgical services, performed in a hospital, outpatient department, a doctor's office or any other licensed health facility, but only in the event that such charges would have been reimbursed by your Insurance had a person engaged continuously in the hospital as a registered patient or confinement in a skilled nursing facility.

However, necessary services, supplies and home infusion therapy administered or used by Active Health Care Professionals or providing Home Health Services are covered. Home Health Services do not include services by a person who is a resident of your home or your dependent's home or who normally resides in your home or your dependent's home or a caregiver of your person or a Home Health Care Professional.



The following services are provided to you and your dependent while you are covered in the United States and are subject to the Health Benefit. Services include inpatient, outpatient and home care services, pharmaceutical services, and other Health Benefit services. Through services provided in the United States, you are covered by the Health Benefit. Services provided in the United States are:

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inpatient Care Services

charges made for a person who has been diagnosed as having an illness or injury to him, and is being treated in the following Hospital Care Services provided under a Hospital Care Program.

- by a Hospital Facility for Inpatient and Outpatient and Supplies;
- by a Hospital Facility for services provided as an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor, or ordained minister for individual and family counseling;
- for pre-surgical treatment, including drugs, medicines, and medical supplies;
- by an Other Health Care Facility for:
 - post-operative treatment nursing care by or under the supervision of a Nurse;
 - post-operative treatment services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies, drugs and medicines (including dependent care on the written prescription of a Physician, and laboratory work, but only to the extent such charges would have been payable under the policy if the person were Covered in a Hospital or Hospital Facility).

The following charges for Hospital Care Services are not included as Covered Expenses:

For the services of a person who is a member of your family as your Dependent's legally or who normally resides in your home as your Dependent's person.

For any period when you or your Dependent is not under the care of a Physician.

For services or supplies not listed in the Hospital Care Program.

For any charges or fee prepayment provisions.

It is noted that any other benefits are payable for these expenses under the policy.

For services or supplies that are payable to the policy owner, independent of daily living.

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Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat any mental disorder other than Biologically-Based Mental Disorder, or other than a disorder induced by Substance Abuse. The impact of the behavior, feeling and thinking or thought processes of a person, regardless of medical origin. Services for Biologically-Based Mental Disorder are specifically excluded hereunder because these services are provided, as an "Other Health Care" as part of Medical Benefits coverage. In determining how far possible, charges made for the treatment of any physiological condition related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that require diagnosis, care, and treatment. In determining whether possible, charges made for the treatment of any physiological condition related to substance abuse are excluded or drug abuse or addiction will not be considered as to charges made for treatment of Substance Abuse.

Outpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Covered in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization Services are services that are provided for not less than 4 hours and not more than 12 hours in any 14-day period.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social behavioral disturbances that are a result of certain Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychiatric and social disturbances that are the result of Mental Health conditions, provides a structured, professional supervised treatment program, under the supervision of a Physician, provides 24-hour care, in which a person lives in an open setting, and is treated in accordance with the terms of the appropriate legally authorized agency as a residential treatment center.

A person is considered Covered in a Mental Health Residential Treatment Center when she has a diagnosed and



room in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Qualified Mental Health Services

Services provided by those who are qualified by their Mental Health certification or provided by an independent body, while you are not Dependent or not Confined in a Hospital, and is provided to an individual, group, or Mental Health Intensive Services. Services provided include services include, but not limited to: supported housing or residential care such as: 1) a supervised living facility with daily monitoring, medical interventions or services related to chronic diseases, such as prevention or depression, emotional illness associated with further problems or distress; 2) substance treatment or counseling or group support therapy; 3) other disorders, such as personality disorders or eating disorders; or 4) other treatment of chronic Mental Health conditions, such as depression and bipolar prevention and treatment, and recovery.

Mental Health Intensive Outpatient Therapy Program consists of targeted services or physical treatment that are provided by a certified licensed Mental Health program, where Outpatient Therapy Programs provide a comprehensive individual, family and group therapy on a day, totaling 2 to 6 hours a week.

Partial Substance Abuse Rehabilitation Services

Services provided for rehabilitation while you are not Confined in a Hospital, where required for the group and treatment of abuse or addiction to alcohol and/or drugs. Substance Abuse Services include Partial Hospitalization Services and Residential Treatment Services.

Services for the treatment of alcoholism will be provided, but the "acute phase of treatment" or any other phase that you plan when such treatment is provided by a physician.

Partial Hospitalization Services are provided that are provided not less than 5 hours and not more than 22 hours in any 24-hour period.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the diagnosis and treatment of the psychological and social functioning. Substance Abuse Services include Substance Abuse Services.

Substance Abuse Residential Treatment Center includes an inpatient residential facility for the treatment of psychological and social disorders that are the result of Substance Abuse, such as substance abuse, psychological disorders, substance abuse, and the supervision of Physicians, providers 24-hour care in which you are not in an open setting, and is provided in accordance with the laws of the appropriate legally certified agency or a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when you are a dependent or patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided by the diagnosis and treatment of abuse or addiction to alcohol and/or drugs while you are not Dependent or not Confined in a Hospital, including outpatient rehabilitation or an intervention, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of targeted services or physical treatment that are provided by a certified licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a comprehensive of individual, family and group therapy on a day, totaling 2 to 6 hours a week.

Substance Abuse Rehabilitation Services

Diagnosis and related medical services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs will be provided under the "acute phase and conditions" or any other illness under the plan.

Diagnosis and related medical services are provided when required for the diagnosis and treatment of addiction to drugs. Cigna will decide, based on the Medical Necessity of such treatment, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- any Mental Health services in connection with therapeutic-based Medical Claims;
- any acute medical treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or treatment requirements under Medically Necessary and otherwise covered plans that policy or agreement;
- treatment of disorders which have been diagnosed as organic mental disorders associated with preexisting dysfunction of the brain;
- developmental disorders, including but not limited to: developmental reading disorders, developmental disabilities, developmental language disorders or developmental coordination disorders;
- counseling for maintenance of an existing mental illness;
- counseling for borderline personality functioning;
- counseling for occupational problems;
- counseling provided as a requirement of court;
- treatment or diagnosis of counseling.

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orthopedic prostheses which are determined medically necessary under licensed provider's Prescription for the replacement or correction of injury. Excludes or is ~~excluded~~ defined:

external prosthetic appliances and devices that attach to external prosthetic appliances and devices, orthoses and orthotic devices, braces, and splints.

Orthotic Prosthetic Appliances and Devices

orthotic prosthetic appliances and devices are defined as required replacements for missing body parts. Orthotic prosthetic appliances and devices include, but are not limited to:

upper limb prostheses;

~~terminal~~ devices such as hands or feet, and

speech prostheses.

Braces and Orthotic Devices

Braces and orthotic devices are defined as orthopedic appliances or appliances used to support, align, restrict or correct deformation. Coverage is provided for custom foot braces and other orthoses as follows:

Healed orthoses – only the following custom orthoses are covered:

- rigid and semirigid custom fabricated orthoses;
- semirigid prefabricated and flexible orthoses; and
- rigid prefabricated orthoses including propulsion, lifting, and brace orthoses, such as bars and straps.

Custom foot orthoses – custom foot orthoses are only covered as follows:

- for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
- when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
- when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated foot) and is necessary for the alleviation or correction of injury. Excludes or is ~~excluded~~ defined as:
- for persons with overgrown or deformed skin conditions (e.g. verrucae) pain, bursitis, open wounds, pressure sores, sprains, malalignment, or pathological protrusion of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

prefabricated foot orthoses;

clinical taping and/or custom orthoses. When such a device is excluded except when used postoperatively for the

postoperative program only. When used for the indication, the custom orthosis will be subject to the limitations and exclusions of the External Prosthetic Appliances and Devices benefit.

- orthoses that are additional prostheses for lost orthopedic devices, such as modifications and liners;
- orthoses primarily used for comfort (such as footpads, insoles, and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A brace is defined as an external or orthopedic appliance that supports or holds in correct position the movable part of the body and that allows the motion of that part.

The following braces are specifically excluded: Copes or Jones Braces.

Splints

A splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement will be provided when anatomical change has rendered the external prosthetic appliance or device ineffective. Anatomical change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
 - no more than once every 14 months for persons 19 years of age and older;
 - no more than once every 11 months for persons 13 years of age and under; and
 - replacement due to a surgical affliction or revision of the unit.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and functional devices; and
- prosthetic prostheses prosthetic prostheses.

Exclusions

Behavioral Exclusions

- Claims and funds for services related to diagnosis of infection and treatment of infectious such as a combination of infection and



body length and tail length (TBL) and all but limited to voluntary sleep (including voluntary sedation) medication, approved surgery and other therapeutic procedures that have been demonstrated to causing post-operative resolution based on scientific literature to have a reasonable likelihood of resulting in pregnancy (including reproductive sperm retrieval), behavioral skills, speech, reading or preparation. Approved procedures include: matching, cognitive behavioral therapy, socialization training (HIT), and the use of an individualized

program. The following are non-pharmacological agents that may:

reversal of some non-voluntary sedation;

voluntary recovery from the sedation is caused by an external voluntary medication;

do not change and increase range of behaviorally necessary to the extent that benefits remain and are available under the program's policy. After benefits for the recipient's own purposes have been paid.

reversal of some non-voluntary sedation and

any experimental non-pharmacological or non-pharmacological procedures or therapies.

in vitro fertilization (IVF), including in vitro fertilization using donor eggs and in vitro fertilization where the solution is transferred to a gestational carrier or surrogate.

Bank and frozen embryos, surrogacy

artificial insemination

other reproductive sperm retrieval (HIT)

cryopreservation transfer (CIT)

artificial insemination is covered for any attempted function of reproductive recovery, such that you are unable to

reproductive medical person.

coverage after two years if the female partner is under 18 years old, or after one year if the female partner is 18 years old or older, or if one partner is considered medically sterile or

carry a pregnancy to term with

stable female partner are covered only

if you have used all reasonable non-pharmacological and medically necessary treatment and are still unable to become pregnant or carry a pregnancy

up to two completed egg retrievals, completed, per lifetime (including those covered under prior plans, but not those provided to new enrollees) and

- if you get all your medical care through

in 2022

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Short-Term Rehabilitative Therapy

Short-Term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, motor, and ~~rehabilitative~~ or the rehabilitation and postoperative (acute, chronic) therapy, when provided in the most medically appropriate setting.

The following limitations apply to Short-Term Rehabilitative Therapy:

- occupational therapy is provided only for purposes of enabling patients to perform the activities of daily living after an illness or injury or surgery.

Short-Term Rehabilitative Therapy services that are not covered include but are not limited to:

1. sensory integration therapy, group therapy, treatment of chronic behavior modification or developmental therapy for dysfunction, such as stuttering or other communication, social conditions without evidence of an ~~underlying~~ medical condition or neurological disorder.
2. treatment for functional activities that are not a correction of tongue thrust, lip, verbal or other communication dysfunction that is not based on an underlying diagnosed medical condition or injury, and
3. management or preventive treatment consisting of routine, long-term or non-therapeutic treatment or prevention of disease or to maintain the patient's current state.

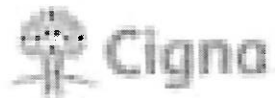
Multiple outpatient services provided on the same day constitute one day.

A separate Copayment will apply to the services provided by each provider.

Services that are provided by a caregiver, physician, or other covered health services include the active or passive management of acute musculoskeletal conditions through manual therapy, manipulation and other physical and treatment modalities to reduce chronic pain and improve function.

Acupuncture Care Services

Coverage for diagnostic and treatment services is limited to an office setting by a licensed acupuncturist. Coverage for treatment includes the appropriate management of acute musculoskeletal conditions through manual therapy and manual physical management (including) non-pharmacological, non-surgical, non-invasive, non-pharmaceutical, and non-pharmaceutical treatment, such as acupuncture, massage, and other physical therapy. For more information, please visit our website at www.cigna.com.



the benefits are only available when the covered person is dependent on ongoing treatment. The benefits are available in the covered person's home.

www.

www.

inclusion, Exclusion Not Covered and General Limitations

Exclusion and Exclusion Not Covered

Medical coverage limitations determined by plan or rider type are shown in this table. Payment for the benefit is specifically excluded from this plan.

Cost for health insurance that are required to meet a health law to be treated in a public facility.

Cost required by state or federal law to be supplied by a public school system or school district.

Cost for military service discontinue treatment through governmental agencies if you are legally entitled to such treatment and the claim is reasonably available.

Treatment of a military, non-military, or civilian, or civilian, or injury which is the result of a covered or non-covered military institution exclude treatment of an illness or injury suffered as a result of war or armed conflict of the illness or injury occurs while the covered person is serving in the military, armed or as a result of any military, non-military, or civilian, or international organization, and as a result of the special health insurance provided to any persons who contribute and supporting or non-contributing such forces, provided the illness or injury occurs while the covered person is serving in such war and is within the United States of America, Puerto Rico, U.S. Virgin Islands, the District of Columbia or Canada.

Certain institutions exclude treatment of illness or injury suffered as a result of war or as a result of war while the covered person is not in the military, armed or as a result of any military, non-military, or civilian, or international organization, or as any civilian non-contributing and supporting or non-contributing such forces, provided the illness or injury occurs within the United States of America, Puerto Rico, U.S. Virgin Islands, the District of Columbia or Canada.

Charges which you are not obligated to pay or for which you are not billed as the health care would not have been billed except that they were covered under this plan.

Services in the treatment of daily living, related to the care of the patient, including, but not limited to, other health-related

services or self-care activities, homebased services and services primarily for care, treatment or rehabilitation purposes.

- The following conditions are excluded from coverage of experimental, investigational or unproven services, except for those non-experimental or unproven for which a health care provider has been assigned for the treatment of the particular condition or standard reference comparison to a medical literature. Experimental, investigational and unproven services are defined as surgical, diagnostic, preventive, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are deemed by the attending review physician to be:
 - not demonstrated through existing peer-reviewed evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or condition for which it is proposed;
 - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
 - the subject of a study or approved by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
 - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- Cosmetic surgery and therapy. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological dysfunctionality or psychological conditions related to one's appearance. This exclusion does not apply to the necessary care and treatment of a Dependent child from the treatment of birth with a medically diagnosed congenital defect or birth abnormality.
- The following services are excluded from coverage regardless of clinical indication: Massage, or Government-Sponsored, Surgical treatment of ear, nose, throat, Adenotomies, Tonsillectomies, Rhinoplasty, Otoplasty, Endonasal sinus surgery, Removal of skin tags, Acupuncture, Transcranial-cranial therapy, Dance therapy, Movement therapy, Applied kinesiology, Reflexology, and Libanopuncture, except where indicated (LAW) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, orthodontics, repairs, orthodontics, periodontics, root, crown and services for dental malocclusion, for any condition, charges made for insertion, replacement procedures for or a replacement with an artificial device to avoid natural teeth are covered provided a continuous course of dental treatment is needed within six months of an accident, trauma, natural tooth loss or



Infused or injected with fluid for the treatment of blood disorders, such as hemophilia, must support and not function as the

member and support services, must and repeat, provided by the member, a medical or nursing center for treatment of diabetes, mental health services or services in Certified Community Health Centers, must and support services to give support to services or changes that are the result of any support provided for the management of chronic or

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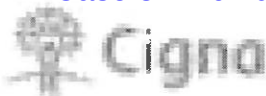
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will be accepted with the intention or disposition of blood or blood products, except for autologous donation in conjunction with a scheduled surgery when in the discretion of the Physician reporting the likelihood of transfusion equal to or greater than 100ml, or when it is a required element to surgery.

Need assessment for the purpose of general assessment in physical condition.

Cost of technology that are contraindications to medications for the purpose of liver or to protect against compromised health and safety.

Costs of dietary supplements and health and beauty aids, vitamins, supplements and hormones except as provided for in Covered Diagnosis.

Cost of or reimbursement with or history of treatment arising out of or in the course of any employment for wage or profit telephone, email, and internet communications, and telemedicine.

Acupuncture therapy.

Algorithms, unless a Physician certifies in writing that the algorithm would challenge the life of the member, or the algorithm are required to meet medical complications that is necessary.

General Limitations

Payment will be made for expenses incurred for part or any of your Dependents.

For charges made by a hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a liability within extended injury or sickness.

To the extent that part or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

To the extent that payment is indicated when the person resides where the expenses are incurred.

For charges which would not have been made if the person had no insurance.

To the extent that they are more than Maximum Reasonable Charges.

To the extent of the maximum approved for any contribution reimbursement shown in this plan.

Expenses for supplies used, treatment or surgery that are not medically necessary.

Charges made by any covered person when in a situation of emergency or your Dependent's injury.

Expenses incurred under the United States plan that expenses are payable and that a right to coverage can be determined without appeal.

Physical Injury Protection (PIP) or Short-Term Health Insurance Coverage (STAC)

When expenses are incurred as the result of an Automobile Related Injury, and the covered person has coverage under Physical Injury Protection (PIP) or short-term health insurance coverage (STAC), this section will be used to determine whether the applicable provision coverage that is primary to such coverage is secondary to such coverage. It will also be used to determine the amount payable if the certificate provides primary or secondary coverage.

This certificate provides secondary coverage to PIP when health coverage has been received as primary coverage by or for the person covered under this policy. This election is made by the named insured under a PIP policy and affects that person's family members who are not themselves injured incidents under another automobile certificate. This certificate may be primary for one covered person, but not for another if the persons have separate automobile insurance policies and have made different selections regarding primary of health coverage.

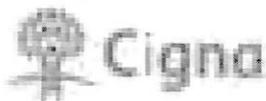
This certificate is secondary to STAC. However, if the STAC contains provisions which make it secondary or excess to the policyholder's plan, then the policyholder's plan is primary.

If there is a dispute as to whether this plan is primary or secondary, this certificate will pay benefits if it is more primary.

If this plan is primary to PIP or STAC, this certificate will pay benefits payable on eligible expenses in coordination with the terms provided in this certificate.

If this plan is the secondary alternative plan which provides benefits to the insured and are payable to secondary insurance coverage, then the plan as provided in the Coordination of Benefits section of this certificate shall apply.

If this plan is secondary to PIP, the actual benefits payable will be the lesser of the maximum allowed otherwise payments after PIP has provided coverage after application of deductibles and copayments, or the actual benefit that would have been payable had the plan been providing coverage primary to PIP.



the extent that the certificate provides coverage that precludes coverage under Medicare, then the plan will be treated as Medicare secondary only coverage or Medicare is primary for auto-enrollment purposes.

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Coordination of Benefits

COORDINATION OF BENEFITS: If you are covered by more than one health plan, you should file all your claims with one plan and provide each plan with information regarding the other plans. Under certain rules, the coverage of one plan may be reduced.

covered period that he covered for health benefits is covered by more than one Plan. For example, he is the only person covered by this policy as an Employee and by another plan as a dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows Cigna to determine at Cigna pays or provides with what another Plan covers or pays. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the covered person is covered.

Definitions

As words shown below have special meanings when used in a provision, Plans and Plan definitions carefully reviewed this provision. These defined terms appear with a capital letter capitalized.

Insurable Event: The charge for any health care services plus the other costs of expenses for which the covered person has the health care services, supply or other items or items is covered at least in part under any of the Plans covered except where a statute requires another definition or otherwise stated below.

how this policy is coordinating benefits with a Plan that covers health care for dental care, vision care, prescription drugs or hearing aids. Allowable Expenses is limited to the cost of expenses.

you will not consider the difference between the cost of a rate hospital cover and that of a group private insurance policy. An Allowable Expense under this plan is a private expense that is reasonable, necessary and appropriate.

how this policy is coordinating benefits with a Plan that coordinates benefits with a group private insurance policy. If you are covered by more than one health plan, you should file all your claims with one plan and provide each plan with information regarding the other plans. Under certain rules, the coverage of one plan may be reduced.

expenses to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A calendar year or any portion of a calendar year during which a covered person is covered by this policy and at least one other Plan and under one or more Allowable Expenses under each plan.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

- Group insurance and group retirement contracts including insurance contained pursuant to a Federal or State continuation law.
- Self-funded arrangements of group or group-type coverage including insurance contained pursuant to a Federal or State continuation law.
- Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance contained pursuant to a Federal or State continuation law.
- Group hospital indemnity benefit amounts that exceed \$100 per day.
- Medicare or other governmental benefits except when payment is law, the benefits must be treated as to extent of those of any private insurance plan or non-governmental plan.

Plans that are not a Plan

- Individual or family insurance contracts or retirement contracts.
- Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans.
- Group or group-type coverage where the cost of coverage is paid solely by the covered person except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan.
- Group hospital indemnity benefit amounts of \$100 or less per day or less.
- Individual accident type coverage.
- A State plan under Medicare.

Primary Plan: A Plan whose benefits for a covered person's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either one of the events:

- The Plan has no order of benefit determination rules, or a rule that differs from those contained in the Coordination of Benefits and Services provision, or
- All Plans which cover the covered person are under all benefit determination rules consistent with those containing



of the Plan shall be of benefits and services provided and under these rules. The plan shall contain the benefits first

available and a summary. An employee that is not covered

by the plan or who is not a participant in the plan shall be provided with a summary of the benefits and services provided and under these rules. The plan shall contain the benefits first

available and a summary. An employee that is not covered by the plan or who is not a participant in the plan shall be provided with a summary of the benefits and services provided and under these rules. The plan shall contain the benefits first

Primary and Secondary Plan

The plan shall be provided to the employee and the employee shall be provided with a summary of the benefits and services provided and under these rules. The plan shall contain the benefits first

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For the Order of Benefit Determination

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the direct costs of benefits determined attributable to such plan is the Primary Plan. The benefits of the Plan that covers the primary insurance or subscription for a longer period of time will be determined before the benefits of the Plan(s) that cover the period for a shorter period of time.

Amount to be Paid by the Secondary Plan is Calculated as:

under the agreement with a provider or claimant is an excess amount.

The amount which the Primary Plan and the Secondary Plan are to settle shall

Whether the provider who provided or arranged the services and supplies is in the network of either the Primary Plan or the Secondary Plan

shall not be based on the diagnosis and customary charges (B & C) or more similar term. This means that the rules for a change and the covered person may be held liable for the full amount of the billed charges. In this section, a plan that covers benefits on a reasonable and customary charge called on "B & C Plan."

shall not be based on a contracted fee schedule.

When called a negotiated fee schedule, or some similar term. This means that although a provider, called a network rate, with a change, the covered person may be held liable for an amount up to the negotiated fee. In this section, a plan that covers benefits on a negotiated fee schedule is called a "Schedule Plan." If the covered person uses the services of a network provider, the plan will be treated as an "B & C" even though the plan under which he or she is covered may be a fee schedule.

When the provider may be based on a "capitation." This means that the HMO or other plan pays the provider a fixed amount per covered person. The covered person is liable only for the applicable deductible, coinsurance or copayment. If the covered person uses the services of a non-network provider, HMO or other plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays rates based upon capitation is called a "Capitation Plan."

The rules below "provider" refers to the provider who refers or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

When Plan is B & C Plan and Secondary Plan is B & C Plan

The Secondary Plan shall pay the lesser of

The difference between the amount of the billed charges and the amount paid by the Primary Plan, or

The amount the Secondary Plan would have paid if it had been the Primary Plan.

but the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in

proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

When Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of

- a. The amount of any deductible, coinsurance or copayment required by the Primary Plan, or
- b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the covered person shall not exceed the fee schedule of the Primary Plan. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

When Plan is B & C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of

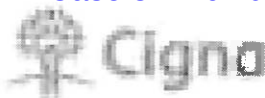
- a. The difference between the amount of the billed charges for the Allowable Expense and the amount paid by the Primary Plan, or
- b. The amount the Secondary Plan would have paid if it had been the Primary Plan.

The covered person shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the covered person has fully satisfied the copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

When Plan is Fee Schedule Plan and Secondary Plan is B & C Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense payment for the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of

- a. The amount of any deductible, coinsurance or copayment required by the Primary Plan, or
- b. The amount the Secondary Plan would have paid if it had been the Primary Plan.



Primary Plan is an HMO Plan and Secondary Plan is a PPO Plan or EPO Plan

The Primary Plan is an HMO plan that does not allow for the use of non-network providers except under certain circumstances, such as emergency care and the service is subject to the second most restrictive form of non-network provider coverage considered under any of your other plans. The Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is a Preferred Provider Plan and Secondary Plan is the Same Plan or EPO Plan

The covered person receives no form of coverage from a provider who is in the network of both the Primary Plan and Secondary Plan; the Secondary Plan shall pay the amount of the payment of any deductible, copayment, or coinsurance required by the Primary Plan, as:

The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is a Preferred Provider Plan or Preferred Provider Plan or EPO Plan and Secondary Plan is a Preferred Provider Plan

The covered person receives no form of coverage from a provider who is in the network of the Secondary Plan; the Secondary Plan shall be liable to pay the expenses of the visit and shall not be liable to pay the deductible, coinsurance or copayment required by the Primary Plan. The covered person shall not be liable to pay any deductible, coinsurance or copayment of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO

The Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of a genuine emergency care and the service is subject to the second most restrictive form of non-network provider coverage considered under any of your other plans; but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan, except that the Primary Plan shall pay out-of-network services of care authorized by the Primary Plan.

- (i) an active Employee's Dependent, as a former Employee's Dependent, who is eligible for Medicare and whose insurance or reimbursement cannot be provided as provided in this plan;
- (ii) an Employee whose Employee and each other Employee participating in the Employee's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;
- (iii) the Dependent of an Employee whose Employee and each other Employee participating in the Employee's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- (iv) an Employee or a Dependent of an Employee of an Employee who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
- (v) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Cigna will remain the amount payable under:

- a. Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied;
- b. Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled;
- c. Part D of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This subsection will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (i) through (v) above.

or more

or more

Payment of Benefits

To Whom Payable

Medical benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is assigned benefits of assigning a patient's ~~assignment~~ to the charge, it is the provider's responsibility to maintain the patient. Because of Cigna's contracts with providers, all claims from contracted providers shall be assigned.

Eligible

You will pay as the Secondary Plan as provided by the following: Part of (b) as ~~assigned~~ for the following: a former Employee who is eligible for Medicare due to whose insurance is considered for one reason as provided in this plan.



plan may, at its option, make payment to you for the cost of a covered expense from a Non-Participating Provider (NPP) without first being assigned. When benefits are paid to a non-participating provider your dependents are subject to co-insurance the same for

all costs to which benefit is payable as a result of an expense. Cigna is not able to give a credit coverage for any cost that has not yet been paid for due to the legal nature of an expense has been made by the legal nature of the cost of an expense. Cigna will not pay for the cost of a claim if it is not paid for by the provider. Cigna is obligated to provide to have received the results of support.

Even if the participant pays their Cigna may require that the cost of a claim has been established. The cost has the same right as an insured and benefit payable for assigned costs should be made payable to the member.

your address and phone will inform Cigna from all liability for the cost of any payment made.

Cost of Payment

will be paid to Cigna within 30 days after it receives information by electronic means and within 60 days after it receives a paper claim by other than electronic means. A claim will be considered to be properly submitted if it is an eligible claim for a health care service provided by a Physician or insured, the claim has no material defect such as missing information, the information is incorrect, there is no proof regarding the amount of the claim. Cigna has no obligation to have the claim is fraudulent, and the claim must be paid in full. Cigna will not pay for a claim if it is a claim in which or in part denied, eligible, or complete reimbursement documentation, including as complete satisfaction, the amount is in dispute, or requires special review. Cigna will be writing or by electronic means or provide your explanation of the claim, what documentation is needed to process a claim, a disputed claim, and, if a claim is denied, Cigna will provide a list of reasons for a claim for electronic means or within a time waiting days following receipt of the information of claim. An insured person that has a claim denied at rate of 12% per annum.

Assignment of Payment

When an assignment has been made to Cigna, Cigna will have the right, as provided for in the terms and conditions of the assignment, from the person to whom or to whom benefit is made, to effect the amount of that assignment from a future claim payment.

Calculation of Covered Expenses

Cigna, at its discretion, will calculate a covered expense following evaluation and verification of all provider's charges in accordance with

- a. the methodology in the most recent edition of the Current Procedural Terminology
- b. the methodology is reported by primary, secondary, professional or professional

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Termination of Insurance

Employees

Your insurance will continue on the earliest date below:

- a. the date you cease to be an eligible Employee or cease to qualify for the insurance
- b. the last day for which you have made any required contribution for the insurance
- c. the date the policy is terminated
- d. the last day of the calendar month in which your Active Service ends except as described below

Any continuation of insurance must be based on a plan which provides individual insurance.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary loss of service of absence, your insurance will be continued with the following Employees' short-term plan for you, as otherwise cannot pay insurance. However, your insurance will not be continued for more than 60 days from the date your Active Service ends.



any or sickness

your Active Sickness state due to an Injury or Sickness, your coverage will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. While your coverage will not continue past the date you are no longer paying premiums for your otherwise covered insurance.

premiums

A maximum limit of your Dependents will remain on the last day before:

the date your insurance ceases:

the day you cease to be eligible for Dependent Insurance;

the last day for which you have made any required contribution for the insurance;

the date Dependent Insurance is cancelled;

a premium for any one of your Dependents will cease on date that Dependent no longer qualifies as a Dependent pursuant to Medical Insurance After Your Death;

even are insured for Medical Insurance when you die, any of a Dependents who are then insured for such insurance, will not be insured, provided the premiums are paid until the last of the following date:

the 180th day after your death;

if a surviving spouse remarries, the date he remarries or the 180th day after your death, whichever is later;

if a Dependent becomes eligible for Medicare, the date he becomes eligible or the 180th day after your death, whichever is later;

the date Dependent ceases to pay any required premiums for the insurance;

the date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you;

a Dependent begins to pay for after you die will be there as one of your Dependents on the day prior to your death.

even,

even
even

Eligibility

with Continuation of Medical Insurance - Total
eligible

your insurance would otherwise cease due to total disability if you have been insured for at least three consecutive years under the policy, and if you pay your Corporate the

required premium, your Medical Insurance will be continued until the expiration of:

a the last day for which you have paid the required premium;

b the date you become employed and eligible for another

insurance under another group policy for medical and dental benefits;

c the date the policy is cancelled;

Within 11 days after the date the insurance would otherwise cease, you may elect to be continuously re-insured by completing a continuation application and by paying the required premium for each Employee.

If your insurance is being continued as outlined above, the Medical Insurance for one of your Dependents insured on the date your insurance ceases otherwise ceases may be continued subject to the above provisions. The Dependent Medical Insurance will be continued until the earlier of:

a the date your insurance ceases or

b with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent;

This option will not operate to reduce any contribution of insurance otherwise provided.

Continuation of Coverage for Dependent Children under New Jersey Law

A Dependent child of a Covered Person who meets the qualifying age for coverage of a Dependent is eligible to continue coverage for himself until his 19th birthday, provided he meets all of the following "Special Eligibility Criteria" for this continuation coverage:

- a is a Covered Person's child by blood or by law, and
- b has reached the qualifying age as specified under his parents' policy, but has not yet reached his 19th birthday; and
- c is unmarried; and
- d has no Dependents of his own; and
- e is either a resident of New Jersey OR is enrolled as a full-time student at an accredited public or private institution of higher education; and
- f is not covered under any other group or individual health benefits plan, and is not eligible to become one under Medicare.

To retain continued coverage under this provision, the Dependent child must make a written election for continuation coverage as a Dependent, complete any necessary enrollment forms and pay the premium, or any of the following times:

a within 30 days prior to the expiration of coverage at the qualifying age provided in his Plan; or

b within 60 days after receiving the "Special Eligibility" Notice, electronically which coverage for the Dependent under this Plan previously terminated or



during an open enrollment period (if provided in the Plan) of the Dependent child meets the "Special Eligibility Criteria" during the open enrollment period; or

for the next 12 months after the effective date of any separation, from 9/12/2006 to 9/11/2007, only a Dependent child meeting the "Special Eligibility Criteria" whose coverage as a Dependent under a Covered Person's policy terminated prior to 9/12/2006 due to ~~attainment~~ of reaching age under such Covered Person's policy;

Dependent child is only entitled to make an election for continued coverage if the Dependent child was actually covered under any parent's Plan on the date he reached the limiting age and was terminated due to reaching such limiting age.

Continued group health benefits, the Dependent child must elect all of the requirements specified in this section and must be written electing to do. The effective date of the dependent child's continued coverage will be the later of the date the Dependent child requests continued coverage with or the date the Dependent meets all of the "Special Eligibility Criteria." This continued coverage is considered upon the dependent child completing the required enrollment form and doing so the first month's premium due. The Dependent child covered under this continuation benefit must pay required premiums monthly, in advance, at the amount and in manner specified by us. Premium payments, other than the first premium payment, will be considered timely if payment made no later than 30 days of the date each premium payment is due.

A Dependent child whose coverage has not yet terminated is to the attainment of the limiting age as specified under this Plan. The written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age.

A Dependent child who did not qualify for this continued coverage because he fails to meet all the "Special Eligibility Criteria," but who subsequently meets all of the "Special Eligibility Criteria," written election must be made within 30 days after the Dependent child has subsequently meets all of requirements.

In addition specifically for the Dependent child a explained greater detail as follows:

If a Dependent child did not qualify because he or she was married, the election must be given within 30 days of the date he or she is no longer married.

If a Dependent child did not qualify because he had a Dependent of his own, the election must be made within 30 days of the date he no longer has a dependent.

If a Dependent child did not qualify because he or she was not a resident of New Jersey or was not 18-21 years old at the time of election, the election must be made within 30

days of the date he becomes a resident of New Jersey or becomes a full-time student at an educational institution.

- If a Dependent child did not qualify because he was covered under another group or individual health benefit plan, group health plan, health plan or health benefits plan, or was entitled to Medicare. The election must be made within 30 days of the date he is no longer covered under any other group or individual health benefits plan, group health plan, health plan or health benefits plan, or is no longer entitled to Medicare.

Each year, there will be an Open Enrollment Period as specified under this Plan during which a Dependent child who previously did not elect to continue coverage, may make an election to continue coverage.

A Dependent child who qualifies for this continuation coverage as of May 12, 2006, having reached the limiting age under his parent's plan and lost coverage prior to May 12, 2006 due to reaching such limiting age, may give written notice of an election for continued coverage at any time beginning May 12, 2006 and continuing until May 11, 2007.

A Dependent child who was covered under prior Creditable Coverage that ~~terminated~~ no more than 90 days prior to making an election for continuation under this section will be given credit for the time he was covered under the Creditable Coverage toward the application of the Pre-Existing Condition Exclusion under the Policy.

The continued coverage shall be identical to the coverage provided to the Dependent child contingent's parent who is covered as an Employee under this Plan. If coverage is provided by Dependents who are under the limiting age as specified in this Plan, the coverage for Dependent child contingent shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

The Group is required to verify the Dependent child is meeting all the criteria to continue coverage and the status of continuing coverage at the following times:

- including the coverage of the Dependent contingent due to reaching the limiting age; and
- all the time coverage terminates because the Dependent child no longer meets the "Special Eligibility Criteria" except that notice is not required when the Dependent child later:
 - gives birth a dependent of his own; and
 - turns 18 or open enrollment period; and
 - immediately following 9/12/2006, for the subsequent 12 months.



Termination of coverage under this section will end on the first of the following dates:

the date ending the period for which premiums has been paid for the Dependent child continued subject to the Group Period for such premium on

the date the Group ceases to provide coverage to the Covered Family when is the Dependent child's parent or

the date the Plan under which the Dependent child continuously coverage is intended to delete coverage for Dependents or

the date the Dependent child ceases to continue to meet any of the "Active Eligibility Criteria" requirements or

the date the Dependent child's parent who is covered as an Employee under the Plan ceases Dependent coverage except if the Employer has no other Dependents, the Dependent child continues to coverage will end and as a result of the Employer ceasing Dependent coverage.

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Continuation

if coverage may not be continued (automatically terminated) Cigna is the plan sponsor unless the plan sponsor is an individual or a person working coverage on behalf of the individual, otherwise an act, practice or custom that addition based on the plan sponsor is individual or a person working coverage on behalf of the individual under an actual representation of material fact.

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Medical Benefit Extension Upon Policy Termination

The Medical Benefit under this plan ceases for you or your dependent on the termination of the policy, until you are a dependent is 180 days (extended on that date due to no work or sickness). Medical Benefits will be paid for 180 days proper on record in connection with that injury or sickness. The 180 days benefits will be paid after the expiration of the date you are covered for 180 days (benefit of any claims on the 180 days).

the date you are covered for medical benefits under another group policy.

the date you are no longer 180 days (benefit of any claims) benefits for that standing condition are being paid for you under the existing policy.

11 months from the date your Medical Benefit ceases or

11 months from the date the policy is renewed.

Excluded Events

You will be considered "Totally Disabled" if because of an injury or a sickness:

- you are unable to perform the usual duties of your occupation, and
- you are not performing any other work or engaging in any other occupation for longer period.

Total Dependents will be considered "Totally Disabled" because of an injury or a sickness:

- he is unable to engage in the usual activities of a person of the same age, sex and ability, or
- in the case of a Dependent who actually works for wages or profit, he is not performing such work.

Eligible Status: The terms of the Medical Benefit Extension will not apply to a dependent as a result of a program which exists when you or your Dependent's Medical Benefits cease.

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Federal Requirements

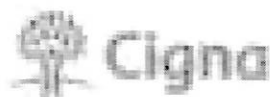
The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a federal provision directly applies to this benefit, the provision which provides the better benefit will apply.

Page 17 of 14

the of network processes is available to you without charge. Simply, the network is by using the phone network as you wish. The network consists of providers, including public, of course, and also as well as general practice. There is a network of 10,000 or so organizations, including the one listed.

Other authors have found that support status is associated with the level of support provision and that the level of support provision is associated with the level of support provision.

• Letter of Complaint to the State Department on Children's Health Insurance Program (CHIP) If you happen to be disappointed, move forward under a state Medicaid or CHIP plan and the coverage is better than that for a lot of children, you can request special enrollment for yourself and any affected children if you are not already insured.



in the Plan. You must request enrollment within 30 days after termination of COBRA or a COHP coverage.

Loss of eligibility for other coverage following continuation coverage.

Coverage may be lost under this Plan due to coverage under another group health plan. For the other coverage to lose you and all of your eligible Dependents is your request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously denied, it may later be denied in writing with a statement that the reason for denying enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:

- decrease in legal separation;
- cessation of ~~Dependent's~~ status (such as reaching the limiting age);
- death of the Employee;
- termination of employment;
- reduction in work hours to below the ~~minimum~~ required for eligibility;
- you or your Dependent(s) no longer reside, live or work in the other plan's network or that area and no other coverage is available under the other plan;
- you or your Dependents were a class which moves or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
- the other plan no longer offers any benefit to a class of similarly situated individuals.

Termination of Employer contributions following continuation coverage. If a reason to terminate Employer contributions toward the Employee's or ~~Dependent's~~ other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependents.

Exclusion of COBRA or other continuation coverage.

Special enrollment may be requested in this Plan for you and all of your eligible Dependents upon termination of COBRA or other continuation coverage. If you or your Dependent(s) select COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be selected prior to any new or reinstated rights exist under this Plan. An individual is considered to have requested COBRA or other continuation coverage only if such coverage occurs due to failure of the Employer to offer continuation which is equal payments on a timely basis, when the person no longer resides or works in the other plan's service area and there is no other COBRA or ~~continuation~~ coverage available under the plan, or when the individual receives notice that you and yours are covered a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage

available to the individual. This does not include termination of an Employer's payment period of contributions toward COBRA or other continuation coverage as provided under any agreement or other agreement.

- **Eligibility for employment restoration under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependents become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected ~~Dependent(s)~~ who are not already covered in this Plan. You must request enrollment within 30 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

or name

or id

Effect of Section 125 Tax Regulations on This Plan

This Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. For this regulation, you may agree to a salary reduction paid toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash salary.

1. Coverage Elections

For SECTION 125 REGULATIONS, you are permitted to agree to enroll in or change coverage only before each annual benefit period (however, coverage may change if your Employer agrees and you enroll in or change coverage within 30 days of the following):

- the date you start the Special Enrollment process described in item 10;
- the date you start the COBRA election in the following Sections 2 through 11.



Change of Status

change in status is defined as:

- change in status that results due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement or loss (such as death) of a Dependent;
- change in dependent status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, layoff ending or end of national order of attention (including under the Family and Medical Leave Act (FMLA)) or change in workdays;
- change in employment status of Employee, spouse or Dependent resulting in eligibility or requalifying for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

Event Order

change in coverage due to an event consistent with a report under the Employer or other person's cover a Dependent

Eligible as Immediate Eligible/Qualification

A Employee, spouse or Dependent cannot or reduces coverage due to contribution to Medicare or Medicaid or fails to purchase coverage due to loss of Medicare or reduced eligibility.

Change in Cost of Coverage

The cost of benefits payments or amounts during a benefit year, from Employee rate, is associated with plan terms, automatically change with election contribution.

For the change in cost is significant, you may either allow your contribution or what have already coverage. When significant cost reduction is made in the benefit options have elected, it is your cost as they available benefit rate. When a new benefit option is added, you may change or moving to the new benefit option.

Change in Coverage of Spouse or Dependent Under other Employer's Plan

It may make a coverage election change if the plan of your spouse or Dependent makes a change back as making or losing a benefit option, which election change due to your Enrollment. Change in spouse's coverage under an eligible or Medicaid Eligible/Qualification in the Plan and when plan have different priority of coverage or open enrollment periods.

G. Reduction in Work Hours

If an Employee's work hours are reduced under a health benefit plan of a health benefit of the Employer, a long-eligibility for the Employer's coverage and the Employee (and family) intend to work, in another plan that provides ~~Minimum Essential Coverage (MEC)~~. The new coverage must be effective no later than the 1st day of the 1st month following the month that includes the date the original coverage is reduced.

H. Enrollment in Qualified Health Plan (QHP)

The Employee must be eligible for a QHP through a Marketplace or the Employer wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period, and the Enrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

or more

or more

Eligibility for Coverage for Adopted Children

A child who is adopted by you, including a child who is placed with you for adoption, will be eligible for dependent insurance, if otherwise eligible as a Dependent upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be reinstated.

The provisions in the "Exception for Placement" section of this document that describe requirements for placement and affidavit state of intention will also apply to an adopted child or a child placed with you for adoption.

or more

or more

Coverage for Maternity Hospital Visits

Group health plans and health insurance issuers offering group health insurance coverage provide such and under a federal law known as the "Affordable Care Act" (ACA) and "Health Insurance Act" (ACA) must be able to provide the same financial rights of state or community with children for the mother's insurance children, low birth or birth following a medical delivery, so long they do become following a medical delivery, so long they do become



an understanding that the plan or insurance would be providing a benefit of care and protection of the above grounds (and generally) that was provided an attending physician of another institution, in consultation with the mother. This changing the mother is providing evidence that it is the same applicable.

See also the Plan for further details on the specific coverage available to you and your Dependents.

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Women's Health and Cancer Rights Act

(WHCRA)

As known that your plan, as required by the Women's Health and Cancer Rights Act of 1993, provides benefits for certain cancer-related services including all stages of mastectomy and surgery to relieve congenital deformities, the new provisions, and complications resulting from a mastectomy, including lymphedema? Call Member Services at toll-free number listed on page 23 and for more information.

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Group Plan Coverage Extension of Medical

Group coverage and group policies do not extend coverage as provided by law, the state also decides to provide coverage for that coverage (medical of the Medical, if it is a federal). This includes provisions for continuation coverage required by federal law.

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Continuation of Medical Leave Act of 1993 (FMLA)

As per state of the policy that provides for continuation of coverage during a leave of absence, and continuation of coverage following a return to Active Service, are modified the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable.

Continuation of Health Insurance During Leave

As health insurance will be continued during a leave of absence.

For leave, qualified as a leave of absence under the Family and Medical Leave Act of 1993, as amended, and

- you are eligible for coverage under the title of Civil Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or partly by you and your Employer.

Reinstatement of Covered Services Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, your covered services (health, life, and disability) will be reinstated as of the date of your return. You will not be required to satisfy any waiting or health waiting period or the period that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you updated information under the Family and Medical Leave Act of 1993, as amended.

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Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA), was **supplemented** by continuation of health coverage and re-employment in regard to an employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Uniformed Services Employment and Re-Employment Act of 1994.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premiums to your Employer, using the method of the following:

- 18 months from the last day of employment with the Employer.
- The day after you last received a benefit, and
- The date the policy expires.

Your Employer may charge you and your Dependents up to 100% of the total premium.

Reinstatement of Benefits Applicable to all coverage

During coverage while during the leave of absence, coverage you do not have USERRA at the expiration of USERRA and re-employment by your former Employer, coverage for you and your Dependents may be extended if you pay your Employer advance notice of medical notice of your military service leave, and the duration of all military leaves while you



impaired with your current language, does not speak English.

and your Dependents will be subject to only the balance of working period that was not yet expired before the leave gap. However, if an injury or sickness occurs as a potential during the military leave, Full Time Leave can multiply.

even coverage while this plan terminates as a result of non-ability for medical and financial coverage and you are to return duty is calculated before your active duty service members, their continuation rights will continue to apply.

more

more

How Determining Procedures under ERISA

The following complies with federal law. Provisions of applicable laws of your state may supersede.

Provisions Regarding Medical Necessity Determinations

general, health services and benefits must be medically necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of cost or benefit requested, and the type of health plan. Medical Necessity determinations are made on a professional, medical, or performance basis, as described below.

Some services require prior authorization, or notice to be signed. The Certificate describes when a representative is following the review. You or your authorized representative (usually your health care professional) must request prior authorization according to the procedures described in your Certificate, and to your provider's network participation documents or application.

Some services or benefits are designated as not covered, and your representative will receive a written description of active determinations, and may appeal the determination. The procedures are described in the Certificate, or your

provider's network participation documents or application, and the determination notice.

Written Determinations

Each time your representative requests a requested prior determination, Cigna will notify you or your representative of the determination within 45 days after receiving the request. However, if more time is needed due to matters in your plan's contract, Cigna will notify you or your representative more than 45 days after receiving your request. This notice will include the date a determination can be requested, which will be given due to date after receipt of the request. If more time is needed because necessary information is missing, your representative or you will also specify what information is

needed, and you or your representative will provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination period starts when necessary information is not in your file or health plan state is beyond reasonable knowledge of the provider or a health care professional with knowledge of your health condition, when you stress your health cannot be managed without the requested services, Cigna will begin the determination period on an expedited basis. Cigna's review, in consultation with the leading health care professional, will decide if an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 72 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited final determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 5 days by written or electronic notification.

If you or your representative fails to follow Cigna's procedures for requesting a requested prior determination, Cigna will notify you or your representative of the failure and describe the proper procedure for filing within 5 days (or 14 hours, if an expedited determination is requested, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Continued Determinations

When an ongoing review of a claim has been approved for coverage and you wish to extend the approval, you or your representative must request a requested continuation coverage determination at least 72 hours prior to the expiration of the approval period of your coverage of coverage. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 72 hours after receiving the request.

Performance Determinations

When you or your representative requests a coverage determination of a claim for performance determination after medical care has been rendered, Cigna will notify you or your representative of the determination within 45 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control,



you will need to give us more information within 30 days of receiving the request. Our records will include the date a determination can be expected, which will be no later than 30 calendar days of the request.

More time is needed because necessary information is being gathered to make the appeal. The appeal will also specify what information is needed. And you or your representative must make the appeal and information to the appeal within 30 days of receiving the notice. The ~~document~~ is period will be needed on the date you made such a request of necessary information. And the ~~document~~ is period will be needed on the date of your ~~document~~ is response to the notice.

Use of Adverse Determination

any notice of an adverse benefit ~~determination~~ will be stated in writing or electronically, and will include all of the following that pertain to the ~~determination~~. The specific use of language for the adverse determination, reference to specific plan provisions on which the ~~determination~~ is based, a description of any additional material or information necessary to perfect the claim, and an explanation of why such failure to do so is necessary. A description of the applicable procedure and the time limits applicable, including a statement of a "claimant's" status in filing a civil suit under section 502 of ERISA following an adverse benefit determination on appeal, (if applicable), upon request. A list of charges, a review of any internal rule, guideline, benefit or other similar criterion that was relied upon in filing the adverse determination regarding your claim, and explanation of the scientific or medical judgments for a determination that is based on a medical treatment, preventive treatment, or other system treatment or plan, and the use of a claim involving system care, a description of applicable review process applicable to such claim.

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ERISA Continuation Rights Under Federal

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For You and Your Dependents

What is COBRA Continuation Coverage?

Under COBRA, you or your dependent(s) must be given opportunity to continue health insurance when there is a qualifying event. This would result in loss of coverage under Plan. You and your dependent(s) will be permitted to obtain the same coverage under which you or your dependent(s) were covered on the day before the qualifying event occurred. This is the same as the plan's coverage prior to the event no longer available. You and/or your

dependent(s) must choose between options within the first open enrollment period.

What is COBRA Continuation Coverage?

For you and your dependent(s), COBRA continuation coverage is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment or your death (other than gross misconduct);

- your reduction in work hours;

For your dependent(s), COBRA continuation coverage is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;

- your divorce or legal separation;

- for a dependent child, failure to meet age to qualify as a ~~dependent~~ under the Plan.

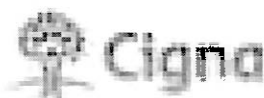
Who is Eligible to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your dependent(s). Each qualified beneficiary has their own right to elect to obtain COBRA continuation coverage even if you decline as you are eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation coverage: partners, ~~qualified~~ ~~beneficiaries~~ identified by your applicable contract adopted by your. Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your dependent(s) even if they are not considered qualified beneficiaries under COBRA. However, each individual's coverage will terminate when your COBRA continuation coverage terminates. The document titled "Secondary Qualifying Events" and "Medical Certification for Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your dependent(s) have elected COBRA continuation coverage and one or more dependents experience another COBRA qualifying event, the affected dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months. If events of the secondary event occur within the 18-month extension period, the maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18



under a COBRA continuation coverage or within the specified maximum period discussed below. Under no circumstances will a COBRA continuation coverage be available for more than 18 months from the initial qualifying event. Individuals qualifying events are initial death, your termination or legal separation, or for a Dependent child, factors necessary to qualify as a Dependent under the Plan.

Initial Determination

After electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or a Dependent is designated by the Plan's beneficiary administrator (SBA) as to finally determined under Title I of the ACA, you and all of your Dependents who have elected COBRA continuation coverage may extend such coverage for an additional 18 months, for a maximum of 36 months from the initial qualifying event.

Specific to the disability extension, all of the following conditions must be satisfied:

SBA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage, and

A copy of the written SBA determination must be provided to the Plan Administrator within 60 calendar days after the date the SBA determination is made. ADI reflects the end of the initial 18-month continuation period.

The SBA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 60 days after the date the final determination is made by SBA. A 18-month disability extension will terminate the all events previous on the first day of the month that is more than 60 days after the date the SBA makes a final determination if the disabled individual is no longer disabled.

Provisions for "Termination of COBRA Continuation" listed are will also apply to the period of disability extension.

Disability Extension for Your Dependents

If the qualifying event is your termination of employment reduction in work hours and you become disabled as defined in Section (Part A, Part II is back) within the 18 months before a qualifying event, COBRA continuation coverage for your dependents will last for up to 18 months after the date you came qualified as Member. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be ~~terminated~~ upon the occurrence of any of the following:

the end of the COBRA continuation period of 18, 24 or 36 months, as applicable;

- a. failure to pay the required premiums within 30 calendar days after the due date;
- b. cancellation of the Long-term package with Cigna;
- c. after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B or both);
- d. after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary was a candidate for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the end of the end of the applicable maximum period, the date the pre-existing condition provision is no longer applicable, or the end of the maximum term set in one or the first three bullets above;
- e. any time the Plan terminates coverage of a participant or beneficiary who is not covering continuation coverage (e.g., death).

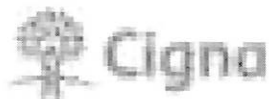
Ending End of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another insurer which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- a. An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) termination under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below;
- b. A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following time frame:
- i. if the Plan provides that COBRA continuation coverage will be provided within which an Employer must notify the Plan Administrator of a qualifying event shall upon the loss of coverage, 180 days after loss of coverage under the Plan;
- c. if the Plan provides that COBRA continuation coverage will be provided within which an Employer must notify the Plan Administrator of a qualifying event shall upon the



occurrence of a qualifying event. 30 days after the qualifying event occurs, or:

- in the case of a newly eligible person, no more than 30 days after the end of the period in which Employment contract provides access to a qualifying event to the Plan Administrator.

• In Effect COBRA Continuation Coverage

- COBRA coverage election notice will let you and others who are eligible for COBRA continuation coverage and any one of the applicable programs. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your choice no later than the due date stated in the COBRA election notice. If a written election notice is required, it must post-date the due date. If you do not make proper

election by the due date shown on the notice, you and your dependents will lose the right to elect COBRA continuation coverage. If you elect COBRA continuation coverage, you will:

- but then you may change your mind as long as you wish a completed election form before the due date.

A qualified beneficiary has an independent right to elect COBRA continuation coverage. COBRA continuation coverage may be elected for only one person, or for all dependents who are eligible beneficiaries. Parents may elect to continue coverage for all of their dependent children. You may also elect to elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your dependents to elect COBRA continuation.

• Make Your COBRA Continuation Coverage Last

A qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 10% of the cost to the group health plan (including both employer and employee contributions) for coverage of a

fully insured active employee or family member. The amount during the 18-month disability extension may not exceed 100% of the cost to the group health plan (including both employer and employee contributions) for coverage of a fully insured active employee or family member.

• Example: If the participant elects direct COBRA continuation coverage, the participant will be charged 10% (100%) of the active employee premium. If the participant is a dependent child who elects COBRA continuation coverage, they will be charged 100% (or 100%) of the active employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged the full 100% of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. Payment must reach your first payment no later than 45 calendar days after the date of your election. (That is the date the election notice is postmarked, if required.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before the due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during that time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be reconstructed once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all right to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your dependent experiences one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the date of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation or
- Your child ceases to qualify as a dependent under the Plan.
- The termination of a secondary qualifying event as that word means "Secondary Qualifying Event" above (that event must be occurred prior to the end of the current 18- or 36-month COBRA period).

[illegible]

100 percent of the 1994 Schedule Through Marriage. Both
 options are available for filers in which case coverage is
 100 percent and they cover their dependent under your
 HRA ~~coverage~~ coverage. However, only that individual
 adopted dependent child is a qualified beneficiary and not
 other 1994 Schedule coverage for the remainder of
 coverage period following your last ~~termination~~ of
 HRA coverage or the next possible qualifying event.
 HRA coverage for your dependent spouse and any
 potential children, minor and non children (e.g.
 children in adult homes) will cover on the day your
 HRA coverage ends and there are no changes for a
 future qualifying event.

you are covered as a spouse and a surviving annuitant listed with respect to the beneficiary under Title II of the Social Security Code, you may be entitled to COLRRA annuitant coverage. If the bankruptcy results in a loss of earnings for you and Dependents of your surviving spouse, then one year before or after such proceeding, you and your listed Dependents will be on COLRRA's qualified list of persons with respect to the bankruptcy. You will be eligible for COLRRA annuitant coverage until your death. If surviving spouse and listed Dependent children will be entitled to COLRRA annuitant coverage for up to 60 months following the death of spouse, COLRRA annuitant coverage will cover until the expiration of one of the events listed under "Termination of COLRRA annuitant coverage."

Make for the Congress and working for my fellow Americans.

These findings have serious implications for the use of the model in a simplified column and beam frame analysis and in the current design of shear walls. A further study is required to investigate:

- The underlying health care provider must be a person qualified to health care provider and that must certify that the individual's participation in care is voluntary and is appropriate based upon the individual meeting the conditions described in paragraph (c)(1) - (3).
- The individual provides written or verbal informed consent establishing that the individual's participation in care that would be appropriate based upon the individual meeting the conditions described in paragraph (c)(1) - (3).

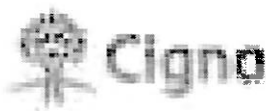
The student that must meet the following requirements:
The state of investigative power

- the agreement is limited for one of the agreements is contained and/or limited by federal law or applicable state law
- the nonaffected parties are not affected by the agreement
- the agreement is not in violation of the public policy of the United States

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for this policy (the "Exclusion of Benefits" or "right to be made whole" because the Plan instrument

Statement of Rights

All participants in the plan are entitled to certain legal protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan documents shall be subject to:

Extra Information About Your Plan and Benefits

Notice, without charge, of the Plan Administrator's office and of other specified documents, such as contracts and other facts, all documents governing the plan, including investment contracts and collective bargaining agreements with a copy of the latest annual report (Form 5500) furnished by the plan with the U.S. Department of Labor, and available in the Public Information Room of the Employee Benefits Security Administration.

Notice, upon request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500) required and updated summary plan description. The administrator may make a reasonable charge for the copies.

Provide a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish such report, under the Plan with a copy of the summary financial report.

When Group Health Plan Coverage

When health care coverage for yourself, your spouse or dependent is there or a form of coverage under the Plan as a result of a qualifying event. You or your dependent may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal coordination coverage rights.

What Actions by Plan Administrator

In addition to creating rights for plan participants, ERISA places duties upon the people responsible for the operation of the employer benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to act in the best interests of you and other plan participants and beneficiaries. You may, according your employee, your self, or any other person with the duty or otherwise, terminate against you or any other person, your benefit, including a welfare benefit or continuing your rights under ERISA. If you think that a welfare benefit is denied or should you have a right to know why, then you should be able to get documents relating to the denial or refusal to charge to appeal the denial, all within 60 days of the denial.

When Your Rights

Under ERISA, there are steps you can take to enforce the rights you have. If you request a copy of documents governing the plan or the latest annual report from the plan

and do not receive them within 30 days, you may file suit in federal court. If such a suit, the court may require the plan administrator to provide the materials and pay you up to \$1,000 a day until you receive the materials. Under the statute, you may not sue for more of damages beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, or which is unpaid, you may file suit in federal or state court.

In addition, if you disagree with the plan's decision to such, there is something the specified steps of a company, you may sue in a federal court support suit. You may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against in exercising your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide what should pay your costs and legal fees. If you are successful, the court may order the person you have sued to pay those costs and fees. If you have the court order order you to pay those costs and fees, for example, if it finds you guilty of discrimination.

Associate with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about that instrument or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20330. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

10/20/2016

10/20/2016

Notice of an Appeal or a Grievance

The appeal or grievance procedure in this instrument may be requested by the plan or your union. Please see your explanation of benefits for the appropriate appeal or grievance procedure.

10/20/2016

10/20/2016

The presence of these mutations indicates that the 1998 outbreak of H5N1 virus infection has a representative or prototype reported by the World Health Organization (WHO) and a Thai virus is present in a domestic Thai bird who also has a low H5N1 virus in her daughter who was infected with virus in *intermediate*.

Complex systems need a classical distributed algorithms framework
 distributed algorithms: complexity, correctness and termination

It has been so taken and held. It was have a specific message, complaint regarding a person, a service, the quality of care, and if a member provides a positive feedback response to a member's comment, you are being recognized for your service. Thank you for taking the time to call our toll-free line and express your comment to one of our Customer Care representatives. You are also assured that comments are kept. Please call or write to us at the following:

It will be very hard to transfer the register on your credit
card. If we spend more money on services or investments from
British, we will just have to put it down as something that is
a loan rather than a transfer charge.

1997 2002 2007 2012 2017 2022 **Agenda: Proceedings**

When I called on Administrative appeal you must send a copy with an appeal on working within 10 days of date of a denial letter. You should state the reasons why your appeal should be approved and include any evidence supporting your appeal. If you are unable to come to a date, you must tell us together your appeal by faxing the written number on your health identification card to our office to designate a representative to appeal on our behalf. Including your personal information. All correspondence that to your appeal will be sent to your designated representative and you. If you do not want such representation we will not require it. If you do not want such representation you must state it upon the first appeal. You must state it upon the first appeal and this representative appealing that later on we will.

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average of requests for a change will be acknowledged in writing within 10 business days. From date of request will be completed within 30 calendar days, while most non-critical requests will be completed within 15 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You will be notified in writing of the decision.

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For appeals regarding a person's access to the quality of care chosen or received (physician, hospital, type of medication,



The contractual benefits of your return described in the Summary of your Complaint and Appeal procedure was sent post to the State of New Jersey Department of Banking and Insurance at the following address and telephone number:

1. Attorney Frederick J. Berman
New Jersey Department of Banking and Insurance
20 West Wall Street, 20th Floor
Newark, NJ 07102
Telephone: 973-261-2700
Fax: 973-261-2700

where the return states in subject New Jersey complaint as it never state any such information.

prote Regarding Requested Medical Necessity and Hamilton System Determination

Medical Determination

you are responsible for making decisions about the appropriateness, medical necessity and efficiency of health services provided to Members under this Certificate. All decisions to deny or limit coverage for an important admission service, a procedure or an extension of important stay, may be by a Licensed Jersey-licensed Physician.

Health care determinations made by Cigna are directly transmitted to the treating or requesting Provider (having a Provider acting on your behalf with your consent) with Provider (if the requesting Provider) as a final basis for payment to the Member's medical needs. Cigna will not give an initial determination of medical necessity or appropriateness unless accompanied or accompanied by information was submitted to Cigna as part of the request for such care services.

your your designated representative (including a provider acting on your behalf with your consent) may request a written list of an initial determination made by Cigna, including an explanation of the Medical Necessity Appeal process.

Medical Necessity Appeals Procedure

you have a two-step procedure for coverage decisions. For your a Medical Necessity appeal, you must submit a request for appeal of writing to the address that appears on your your Identification card, explanation of benefits or plan or within 180 days of receipt of a denial notice. You should include the reasons why you feel your appeal should be approved if include any information supporting your appeal. If you are able to discuss this to with, you may only to request your goal by calling the toll free number on your design's identification card. If you choose to designate a representative appeal on your behalf, including with guidelines, all correspondence related to your appeal will be sent to your designated representative and you. If you do not want such correspondence to pass the appeal on your behalf, you must notify Cigna that you do not want this representative appearing on your behalf.

Level One Appeal

You have the appeal must to appeal, work, and must require appeal review by Cigna's Physicians review.

For level one appeals, we will respond in writing with a decision within 30 business days after we receive an appeal. You may request that the appeal process be expedited if the case involves either that person is would seriously jeopardize your life, health or ability to regain substantial function or as the person is of your Physician would agree you severe pain which could be managed within the requested service, your appeal review must with inclusion of an admission or continuing coverage to your stay, or your appeal extension a determination regarding urgent or emergency care. Cigna's Physicians review, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond with a decision within 24 hours.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the steps process required for a level one appeal, except that such a request must be submitted within 60 days from post receipt of a Level One Appeal decision.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least one Physician reviewer and two other Physicians/health care professionals. Anyone involved in the prior decision may not participate on the Appeals committee. The committee will consult with at least one Physician in the same or similar specialty as the case under consideration, as determined by Cigna's Physicians review. You may request that the name of review specialist be a participant on the committee. You may present your position to the committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within 10 business days and schedule a committee review. The committee review will be completed within 17 calendar days for non-urgent appeals and 20 business days for post service appeals. If more time is necessary to complete or make the determination, we will notify the Department of Banking and Insurance and you in writing to request an extension of up to 10 calendar days for non-urgent appeals and 15 business days for post service appeals and to provide any additional information needed by the Appeals Committee to complete the review. You will be notified in writing of the Appeals Committee's decision.

You may request that the appeal process be expedited if the case involves either that person is would seriously jeopardize your life, health or ability to regain substantial function or as the person is of your Physician would agree you severe pain which could be managed within the requested service, your appeal review must with inclusion of an admission or



submitting responses to your appeal, we will require submission of additional information as part of ~~submitting~~ your appeal. When the goal is expedient, we will respond with a decision within 10 days.

Final Appeals of Insurance Missions See ~~initial~~ ~~final~~

In submitting a Cigna Medical Insurance Appeal, you will be informed of the process. You will be asked to provide an independent External Review Organization (ERO) with a copy of your appeal. The ERO will review the appeal and provide a decision. If you have a concern, you can also provide an independent external review to the State of New Jersey. If you have provided to you and mail the completed form to:

Consumer Protection Services
New Jersey Department of Banking and Insurance
10 West Main Street, 8th Floor
P.O. Box 129
Trenton, NJ 08620-0129
(609) 292-5516

ing with a check or money order for \$10 payable to the New Jersey Department of Banking and Insurance. This fee will be refunded to you in case of financial hardship. If a result is appealing to the ERO on your behalf, the ERO is responsible for paying your portion of the cost of the ERO (e.g. \$25 or \$30 if financial hardship). Cigna will bear remaining costs of the review.

As your Provider, on your behalf, may also request a review your appeal by the ERO. Cigna has incurred any expenses associated with the processing of your request of review appeal. If this is the case, you must notify the ERO that you or your Provider, on your behalf, did not use Cigna from making a timely determination by filing to file the information required for Cigna to make its review.

As the ERO communicates its decision, Cigna will respond within 10 business days to mail to the Provider, on your behalf the ERO and the Department of Banking and Insurance with a written report describing how Cigna will present the ERO's decision.

A Human Appeals Program is a voluntary program. The costs of the ERO's reviewing your appeal.

Appeal to the Office of State Review

You have the right to submit the New Jersey Department of Banking and Insurance for assistance at any time. The New Jersey Department of Banking and Insurance may be contacted at the following address and telephone number:

Consumer Protection Services
New Jersey Department of Banking and Insurance
10 West Main Street, 8th Floor
P.O. Box 129
Trenton, NJ 08620-0129
(609) 292-5516

Notice of Final Decision on Appeal

Every notice of a ~~determination~~ on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- the specific reasons or reasons for the adverse determination;
- information for the specific plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable notice in writing of all documents, records, and other relevant information as defined;
- a statement describing:
 - the procedure to initiate the next level of appeal;
 - any voluntary appeal procedures offered by the plan; and
 - the claimant's right to bring an action under ERISA, section 507(a).
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar information that was used upon making the adverse ~~determination~~ regarding your appeal, and no representation of its contents or status ~~regarding~~ for a determination that is based on a medical necessity, experimental ~~therapy~~ or other similar situation or issue.

You also have the right to bring a civil action under section 507(a) of ERISA if you are not satisfied with the Level Two Appeal decision and wish the Level Two Appeal decision is expedited. You or your plan may have other voluntary alternative dispute resolution options such as mediation. You may find out what may be available to resolve your Level Two Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant information is any document, record, or other information which was relied upon ~~making~~ the health determination and subsequent, considered in processing your request of ~~making~~ the health determination. It does not include whether such document, record, or other information was



and you are seeking the benefit determination, documentation requirements, the administrative processes and independent third-party review of denying the benefit. ~~Additional~~ Additional information is contained in notice or guidance with respect to plans covering the medical treatment options or benefits or treatment options. ~~With respect to whether such~~ With respect to whether such notice or statement was relied upon in making the benefit determination.

and Acting Following Appeals

Under plan as presented by ERISA, you have the right to bring and retain an attorney to act under Section 502(a) of ERISA, and not involved with the outcome of the Appeal. ~~With respect to such matters, you may not initiate a legal~~ With respect to such matters, you may not initiate a legal action against Cigna until you have completed the Level One appeal. Under Appeals processes. If your Appeal is successful, it will be used to complete the Level Two process prior to filing legal action in federal court.

your plan is governed by New Jersey P.L. 2003, c. 107

N.J.A.C. 17:27 et seq. you have the right to bring action in state or federal court with that state. You must exhaust the administrative remedies and Appeals Program process before coming about to section 11 of P.L. 1997, c. 102 (C28-28-11), before filing any action in state court, unless serious or significant injury to the covered person has occurred or will immediately and before filing an action in state court. The message that management has that occurs as a result of Cigna's guidance with respect to the denial of or delay in approving providing medically necessary inpatient services, which may be later is the proximate cause of a covered person's job-related and provided or performance impairment of a daily function or systemic issue of a body organ necessary for normal bodily function, loss of a body member, amputation or fracture or dis-fracturing disease or condition that results serious or significant harm or requires substantial medical treatment, a physical condition resulting in chronic and substantial pain, or substantial physical or mental harm which shall be further substantiated medical treatment made directly necessary by the denial or delay of care.

and

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and

Definitions

Full Service

as well as considered in Notice of Denial.

on day of your day, your scheduled work days if you are performing the regular duties of your work on a full-time basis on that day, then on your Employer's plan of business.

on at least 10 business days prior to your scheduled work days to implement a program.

- on a day which is not one of your scheduled work days if you were on that day on the preceding scheduled work day.

on a day

on a day

Best and Bright

The term best and bright includes all changes made by a hospital on its own behalf for its own and may include all general services and activities needed for the care of hospitalized best patients.

on a day

on a day

on a day

Biologically-Based Mental Illness

A mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, post-traumatic stress disorder, obsessive-compulsive disorder, panic disorder, and personality developmental disorder or autism.

on a day

on a day

on a day

Changes

The term "changes" means the actual paid changes, except when the provider has contracted directly or indirectly with Cigna for a different reason.

Other Related to Third-Party's Definition

The term "changes" means the actual paid changes, except when the provider has contracted directly or indirectly with Cigna for a different reason and with either the provider or a third party or a group of persons or who have "changes" means the agreed upon rate that Cigna agrees to directly pay the provider or third party. The term "changes" means the amount that a third party provides or is agreed to provide up to a provider.

on a day

on a day

on a day

on a day



Therapeutic Care

- **Therapeutic Care** covers the assessment, management of behavioral/psychological conditions through evaluation and ongoing psychological treatment required to help a child to manage chronic, future pain and improve sleep.

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Medical Services

- **Services that are of a diagnostic, preventive, or counseling nature.** Such services may include a visit to an individual setting, at home visit, or visiting services to care someone because of age or mental or physical condition. A service primarily helps the person in daily living. Medical care also can provide medical services, given nature, maintain the person's current state of health. These services are intended to greatly improve a medical condition. A service intended to provide care while the person cares for himself or herself. Covered services include but are not limited to:

Services related to washing or providing a person.

Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, eating, eating, preparing foods, or taking medications that can be self-administered, and

Services not required to be performed by trained or skilled medical or paramedical personnel.

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Parenting

Parents are

those lawful parents or legal guardians and

any child of parent who is

a. less than 18 years old;

b. 18 or more years old, not married and who is not emancipated; and in a domestic partnership, and previously supported by you and incapable of self-sustaining employment by reason of mental or physical disability when you, when the child was covered as a dependent under this Plan, or when covered as a dependent under a prior plan with us would be covered;

Parent of the child's condition and dependent must be reported to Cigna within 30 days after the date the child starts to qualify either. Excludes a child who has not been frequently seen under a plan. Cigna may require proof of the continuation of early treatment and improvement.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild or a child for whom you are the legal provider. If you are a dependent parent has a child that child will also be included as a dependent.

Duration for a dependent child will continue until the end of the calendar month in which the limiting age is reached.

Anyone who is eligible to work anywhere will not be considered as a dependent spouse. A child under age 18 who is eligible to work anywhere and a dependent child must be covered as either self-employed or as a dependent child.

The age will be considered as a dependent of more than one employer.

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Emergency Services

Emergency services are medical procedures, surgical, (trauma) and/or medical health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily injury or serious condition which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of appropriate medical attention. Examples of such injury or condition are conditions that require loss of consciousness or conscious breathing, as well as conditions which may otherwise be diagnosed by Cigna, in accordance with generally accepted medical standards to require immediate medical attention. The covering conditions, included by the provider and covered by the Plan, or by the claim form, or the final diagnosis, will be the basis for the determination of coverage.

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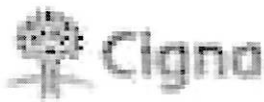
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Limitation

The self-employed person's full time or part time employment at the Employer, who is currently in Active Service. The term does not include employees who are temporary, or who contractually work less than 21 hours a week for the Employer.

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| <p>provider</p> <p>A term that refers to any of the following: a health care provider, a health care organization, a health care facility, or a health care provider organization.</p> | <p>It is intended to be consistent with the terms of the applicable legal instrument.</p> |
| <p>residential health facility</p> <p>A term that refers to any of the following: a health care facility, a health care organization, a health care provider organization, or a health care provider organization.</p> | <p>It is intended to be consistent with the terms of the applicable legal instrument.</p> |
| <p>residential health facility</p> <p>A term that refers to any of the following: a health care facility, a health care organization, a health care provider organization, or a health care provider organization.</p> | <p>Hospice Care Program</p> <p>The term Hospice Care Program means:</p> <ul style="list-style-type: none"> a coordinated interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying patients and their families; a program that provides palliative and supportive medical nursing and other health services through home or hospital care during the illness; a program for persons who have a terminal illness and for the families of those persons. |
| <p>residential health facility</p> <p>A term that refers to any of the following: a health care facility, a health care organization, a health care provider organization, or a health care provider organization.</p> | <p>Hospice Care services</p> <p>The term Hospice Care services means any services provided by a Hospice, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility or any other licensed facility or agency under a Hospice Care Program.</p> |
| <p>residential health facility</p> <p>A term that refers to any of the following: a health care facility, a health care organization, a health care provider organization, or a health care provider organization.</p> | <p>Hospice Facility</p> <p>The term Hospice Facility means an institution or part of a health facility.</p> |
| <p>residential health facility</p> <p>A term that refers to any of the following: a health care facility, a health care organization, a health care provider organization, or a health care provider organization.</p> | <p>Hospice Facility</p> <p>The term Hospice Facility means an institution or part of a health facility.</p> <ul style="list-style-type: none"> a facility that provides care for terminally ill patients; is accredited by the National Hospice Organization; meets standards established by Cigna; and fulfills any licensing requirements of the state in which it is located. |

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Charges for Covered Services are subject to all other policy exclusions and applicable coding and payment instructions as announced by Cigna.

Covered services are not for a ~~specific diagnosis~~ and services that would be charged as would be appropriate.

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referred

The term **Referred** means a state program of medical and health services established under Title XIX of the Social Security Act of 1965 as amended.

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Medically Necessary/Medical Services

Medically Necessary Covered Services and Supplies means or means a health care service that a health care provider, exercising his or her clinical judgment, would provide to a third person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is consistent with the generally accepted standards of clinical practice, clinically appropriate, in terms of type, quantity, extent, site and duration, and considered effective for the covered person's illness, injury or disease, not merely for the convenience of the covered person or the health care provider, and that cannot easily be an alternative route or sequence of services or tests or likely to produce a different diagnosis or diagnostic result or to the diagnosis, treatment or that covered person's illness, injury or disease.

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services

The term **Services** means the program of medical and health services established under Title XVIII of the Social Security Act as amended.

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services Services and Supplies

The term **Services and Supplies** includes all items, except charges for food and board, made by a

hospital or its staff for medical services and supplies actually used during hospital confinement, any charges for laboratory tests, for laboratory examinations, for use of the hospital where the medical service is rendered and for the administration of anesthesia during Hospital Confinement.

The term **Services and Supplies** will not include any charges for special nursing care, dental care or medical care.

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State

The term **State** means a Recognized Health Plan, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N." "L.P.N." or "L.V.N."

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Other Health Care Facility/Other Health Professional

The term **Other Health Care Facility** means a facility other than a Hospital or Skilled Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and recovery facilities. The term **Other Health Professional** means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to, physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistant Technicians, Licensed Certified Surgical Assistant Technicians, Licensed Surgical Assistants, Certified Pharmacy Assistants and Surgical First Assistants.

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CIGNA

PO BOX 182223

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CHATTANOOGA TN 37422

XXX PICA

PICA XXX

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE

DATE

payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 15. OTHER DATE MM DD YY QUAL.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. 17b. NPI

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0
 A. M48061 B. M5416 C. D. E. F. G. H. I. J. K. L.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

20. OUTSIDE LAB? \$ CHARGES
☐ YES ☒ NO

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-10 ID. QUAL. J. RENDERING PROVIDER ID. #

1 09 11 19 09 11 19 22 63047 80 AB 95000 00 1 NPI

2 09 11 19 09 11 19 22 63048 80 AB 3450000 1 NPI

3 09 11 19 09 11 19 22 63048 80 59 AB 3450000 1 NPI

4 09 11 19 09 11 19 22 63048 80 59 AB 3450000 1 NPI

5 09 11 19 09 11 19 22 76000 80 26 59 AB 2400 00 1 NPI

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25. FEDERAL TAX ID. NUMBER SSN EIN 464029458 26. PATIENT'S ACCOUNT NO. 23047 27. ACCEPT ASSIGNMENT? (For gov't claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE \$ 200900 00 29. AMOUNT PAID \$ 623 88 30. Rev'd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

BRIAN A BANNISTER, MD
 SIGNED 05 21 20

32. SERVICE FACILITY LOCATION INFORMATION
 HUDSON REGINAL HOSPITAL
 55 MEADOWLAND PKWY
 SECAUCUS NJ 070942305

33. BILLING PROVIDER INFO & PH # (732) 4932040
 Monmouth County Pain Management
 432 OCEAN BLVD UNIT 201
 LONG BRANCH NJ 077405681

Cigna
Appeals
PO Box 188011
Chattanooga, TN 37422



June 12, 2020

Monmouth County Pain Management
Attn: Purvi Joshi
432 Ocean Blvd. Unit 201
Long Branch NJ 07740



Dear Monmouth County Pain Management,

Your request for a Single Level Provider Payment Appeal for the service referenced above has been completed. After reviewing your request, we have decided to uphold the original decision.

We use a methodology similar to Medicare to determine reimbursement for the same or a similar service within a geographic market. Because we don't have any information that supports a reason to pay more than the Maximum Reimbursable Charge, we won't pay anything more towards this claim.

Additionally, your request for a copy of the benefit plan and all records relevant to the claim determination has been forwarded to the appropriate area for review and response.

This is the final internal level of appeal.

If you are not satisfied with this decision, you may be eligible to seek resolution through a state-contracted arbitration organization (AO), under the provisions of the New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA). This process is

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called the New Jersey Program for Independent Claims Payment Arbitration (PICPA), and the state-contracted arbiter is MAXIMUS, Inc.

To request a PICPA review, you must complete a MAXIMUS application accessible online at www.njpicpa.maximus.com, and submit the application, together with required review and arbitration fees.

If you wish to submit applications by mail, use the contact information provided on the MAXIMUS website at www.njpicpa.maximus.com. Supporting documentation may be submitted online, faxed or mailed using the case number generated through the online submission process. Fees must be submitted by mail at this time and must also include the case number. An application for arbitration will not be considered until the required application fees are received.

If you have any questions, please feel free to call Cigna at 1-800-882-4462. A representative will be happy to assist you.

Sincerely,

Vonda S.
Appeals Processor

Civil Case Information Statement

Case Details: MONMOUTH | Civil Part Docket# L-002063-22

Case Caption: MONMOUTH COUNTY PAIN MANEGEME
VS CIGNA HEALTH A

Case Initiation Date: 07/29/2022

Attorney Name: LORI B SHLIONSKY

Firm Name: CALLAGY LAW

Address: 650 FROM RD STE 565
PARAMUS NJ 07652

Phone: 2012611700

Name of Party: PLAINTIFF : MONMOUTH COUNTY PAIN
MANAGEMENT

Name of Defendant's Primary Insurance Company
(if known): Unknown

Case Type: CONTRACT/COMMERCIAL TRANSACTION

Document Type: Complaint

Jury Demand: NONE

Is this a professional malpractice case? NO

Related cases pending: NO

If yes, list docket numbers:

**Do you anticipate adding any parties (arising out of same
transaction or occurrence)?** NO

Does this case involve claims related to COVID-19? NO

**Are sexual abuse claims alleged by: MONMOUTH COUNTY PAIN
MANAGEMENT?** NO

THE INFORMATION PROVIDED ON THIS FORM CANNOT BE INTRODUCED INTO EVIDENCE

CASE CHARACTERISTICS FOR PURPOSES OF DETERMINING IF CASE IS APPROPRIATE FOR MEDIATION

Do parties have a current, past, or recurrent relationship? NO

If yes, is that relationship:

Does the statute governing this case provide for payment of fees by the losing party? NO

**Use this space to alert the court to any special case characteristics that may warrant individual
management or accelerated disposition:**

Do you or your client need any disability accommodations? NO

If yes, please identify the requested accommodation:

Will an interpreter be needed? NO

If yes, for what language:

Please check off each applicable category: Putative Class Action? NO Title 59? NO Consumer Fraud? NO

I certify that confidential personal identifiers have been redacted from documents now submitted to the court, and will be redacted from all documents submitted in the future in accordance with *Rule 1:38-7(b)*

07/29/2022
Dated

/s/ LORI B SHLIONSKY
Signed